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On Diphtheria. By Edward Headlam Greenhow. 1861. Pp. 160.

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Original Lectures.

LECTURES ON THE PHYSIOLOGY OF THE CRANIAL NERVES.

DELIVERED IN THE COLLEGE OF PHYSICIANS AND SURGEONS.

BY

JOHN C. DALTON, JR., M.D.,

PROFESSOR OF PHYSIOLOGY AND MICROSCOPIC ANATOMY.

LECTURE V.

To-day, gentlemen, we commence the study of the *Pneumogastric* nerve. This nerve originates from the lateral portion of the medulla oblongata, a little behind the glosso-pharyngeal, which we examined yesterday. Like that nerve, the pneumogastric arises by a considerable number of filaments, and, passing from within outwards, enters the same bony canal which contains the glosso-pharyngeal. While passing through this canal, the pneumogastric nerve has upon it a ganglion, through which its fibres pass, and with the nerve cells of which these fibres are closely intermingled. Now the origin and course through the cranial bones, both of the glosso-pharyngeal and pneumogastric nerves, are, as you will see, exceedingly similar; and when we have examined more fully their distribution and functions, I think we shall come to the conclusion that, physiologically speaking, the glosso-pharyngeal nerve is but little more than a part of the pneumogastric; and that the distribution of the pneumogastric filaments is in reality hardly anything more than a continuation of those of the glosso-pharyngeal.

Let us go over in the first place the details of the origin, distribution, and characters of this nerve. You have here a dissected specimen, in which is shown the origin of the pneumogastric, and its course through the bony canal. It originates by a number of filaments from the medulla oblongata, passes from within outwards to the posterior foramen lacerum, pursues its course through the bone, the substance of which is here cut away to show the situation of the nerve, and then runs from above downwards through the posterior part of the neck. In this instance, therefore, you have the pneumogastric nerve passing through the bones of the head in the same way as the spinal nerves pass through the bony walls of the spinal canal below; and the other, and perhaps more important, analogy between them is, that just as the pneumogastric is passing through its bony canal, it has upon it a distinct ganglion, like that on the posterior root of a spinal nerve. By examining the pneumogastric in this preparation, at a short distance from its origin, you will see this ganglion, in which the filaments of the nerve, previously separated from each other, are united together into a single cord. Continuing its course from above downwards, the nerve then emerges from the base of the skull, in company with two others, the glosso-pharyngeal and the spinal accessory.

The pneumogastric is distributed to a number of different regions, and it is on account of this varied distribution, and its wandering course, that it has received the name of the *par vagum*. It is also called *pneumogastric*, because its principal distributions are those to the stomach and the lungs.

In enumerating the principal branches given off by the pneumogastric, and which will now engage our attention, we shall be assisted by a reference to this diagram. At this point, just external to the origin of the nerve, you have its ganglion. Below the ganglion the nerve gives off its first branch, the *pharyngeal* branch, which is distributed to the mucous membrane and muscular coat of part of the pharynx. You will remember that the glosso-pharyngeal nerve is distributed to the remaining portions of the same organ. Then the pneumogastric passes from above downwards through the neck into the cavity of the chest.

During this passage it gives off two very important nerves, which are distributed to the larynx. The first, or the *superior laryngeal*, running off from the anterior part of the pneumogastric from above downwards, and from behind forwards, is immediately distributed to the larynx. This superior laryngeal nerve has properties which are well marked and important. It is especially a sensitive nerve, and is distributed exclusively to the mucous membrane of the larynx, with the exception of a single motor branch, which it sends to the crico-thyroid muscle.

After the pneumogastric nerve has given off its superior laryngeal branch, and has passed through the whole length of the neck, and entered the cavity of the chest, it sends off another very remarkable branch which is termed the *Recurrent* or *Inferior Laryngeal*. It is called recurrent, because after being given off from the pneumogastric, it turns backwards, underneath the arch of the aorta, on the left side, and the arteria innominata on the right, and then retraces its course from below upwards, running in the fissure between the trachea in front and the œsophagus behind, until by this reversed or recurrent direction it has reached the level of the larynx. It then enters the larynx, and is distributed to all the muscles of the organ, with the exception of the crico-thyroid, which, you will remember, is supplied by a filament of the superior laryngeal. We have then these two nerves originating from the same trunk, viz. the pneumogastric, and distributed to different parts of the larynx; the superior laryngeal to its mucous membrane, the inferior to its muscles—a sensitive and motor nerve originating from the same source, and distributed to the same organ. The relations, therefore, of these two nerves in the larynx are very much the same as those of the lingual branch of the fifth pair, and the hypoglossal nerve in the tongue.

After giving off the inferior laryngeal nerve the pneumogastric nerve supplies a number of branches to the lungs, which follow in their course the ramifications of the bronchial tubes. The nerve then enters the cavity of the abdomen, to be distributed to the mucous membrane and muscular coat of the stomach, and finally, by several terminal branches, to the liver.

Such is the anatomical distribution of this nerve. Now let us see what are its properties and its functions. In the first place we find that the pneumogastric at its origin is a *sensitive* nerve. If irritated in the interior of the cranium, by opening the cavity of the skull, and passing a galvano-electric current through the nerve, no convulsive muscular action is produced. On the other hand, if the same irritation be applied to the nerve beyond the situation of its ganglion, convulsive movements are produced, in all the muscles which are supplied by its various branches, viz. the muscular coat of the pharynx, the muscles of the larynx, and the œsophagus and stomach. We find, then, that this nerve, like certain others originating from the head, and like the posterior roots of the spinal nerves, is exclusively sensitive at its origin; but that after its emergence from the cranial cavity, it becomes a mixed nerve, containing motor filaments, derived from inosculation with other motor nerves. The motor nerves with which the pneumogastric inosculates after its passage through the ganglion are the spinal accessory, the facial, the hypo-glossal, and the first and second cervicals.

Now the sensibility which resides in the pneumo-gastric differs to a considerable extent from the ordinary sensibility of the spinal nerves, and other cranial nerves. It is not like that of the fifth pair, for example. On the contrary, the pneumogastric nerve conveys to the medulla oblongata that peculiar sensation which is connected more particularly with the function of respiration. Therefore we are not surprised to find, that although the pneumogastric possesses sensibility, this sensibility is also of a special nature, and not acute, like that of other nerves. The peculiar function of the pneumogastric can be determined by similar means to those which we have employed for the study of the other nerves. We divided the fifth

pair, for example, and found that sensibility was lost in those parts to which the nerve is distributed; and we therefore concluded that it was the function of the fifth pair to confer the power of sensation upon these parts. Now, if we divide the pneumogastric nerve, we find that the effect which is produced is a very peculiar one. For the function of this nerve is not only to a great extent special in its nature, as I have already intimated, but it is also a very *compound* one. As the filaments of the nerve are distributed to many different organs, we therefore have a compound effect produced by its division; and this effect is of such a nature as to require the utmost care and nicety in appreciating the relative importance of the different elements which enter into its composition.

The most remarkable of the effects produced by a section of the pneumogastric have been found to be those which are connected with respiration. This is, in fact, the great nerve of respiration; and consequently, when it is divided, the respiratory function is modified in a very peculiar way. Certain variations show themselves in the results of the operation, but, in the great majority of instances, its principal effect is to *reduce the frequency of the respiratory movements.* We must remember that the pneumogastric is not a motor nerve; the intercostal muscles and the diaphragm have their own nerves of motion, which act independently of each other. If the division of the pneumogastric, therefore, interferes with respiration, it must do so by suspending some peculiar sensation which is connected with the performance of the function. This is undoubtedly the case. Dividing the nerve cuts off a peculiar impression which gives rise to the reflex action of the respiratory muscles. I have here an animal (a dog) in whom the pneumogastric nerves have been already dissected out on both sides of the neck. I will now proceed to expose the nerves and divide them, when you will be able to judge first, of the amount and character of the sensibility which resides in the pneumogastric, and secondly, of the peculiar effect produced by its division upon the function of respiration. You will remember that, in dividing the fifth pair some days ago, notwithstanding the previously etherized condition of the animal, when the sensitive filaments were cut across, their sensibility was so excessive that the animal was partially roused from his unconsciousness, and indicated his uneasiness by distinct cries. In this case, however, the animal has almost entirely recovered from his etherization. If, therefore, the same amount of ordinary sensibility resides in the pneumogastric that we found to exist in the fifth pair, we shall have a very acute pain produced by its division. Generally speaking, however, very little pain is produced even by the section of the entire trunk of the nerve on both sides; and frequently the animal appears utterly indifferent to the operation. A ligature has now been passed around the nerve on each side, so that I can readily lift it from its bed. I will now, in the first place, divide the nerve upon the right side. A very slight indication of sensibility, you see, is the result. I will now do the same thing upon the opposite side, and you will see that here also there is hardly any indication of feeling on the part of the animal. The effect of the division of this nerve upon respiration, however, which will show itself in the course of a short time, is not yet shown by any decided symptoms. This effect of diminishing the frequency of the respiratory movements is accomplished, as I have already stated, by diminishing the animal's desire to breathe. He, therefore, breathes more slowly than before, not from any physical obstacle to the entrance of air into the lungs, but simply because he does not feel the urgent necessity for respiration which usually exists. I will keep this animal, and to-morrow we will again examine his condition. We can then see what progress has been made in the effects produced upon the lungs and other vital organs.

At the same time, however, I must call your attention to another very important effect produced by a division of the pneumogastric in the middle of its course. By this operation we divide, at the same time with the main trunk of the nerve, the filaments of the recurrent laryngeals, and, therefore, we necessarily paralyse the muscles of the larynx. Now the larynx has a very important office to perform in connexion with the process of respiration. There are respiratory movements of the glottis as well as those of the chest, and these respiratory movements of the glottis are almost equally important with those of the thorax. At every movement of inspiration the vocal chords are separated from each other so as to increase the opening of the glottis, and at every expiration they collapse and tend to fall inwards towards each other. Thus, whenever the thoracic muscles act to expand the chest, at the same instant the muscles of the larynx open the glottis in order to allow the entrance of the air. We can see this action of the glottis in some of the lower animals without the necessity of any special operation. In this pigeon, for example, by opening the mouth widely, you can see the glottis situated at the base of the tongue, and opening widely at every inspiratory effort. In order to illustrate this action of the glottis I have here a dog, which I will etherize, and whose glottis I will then expose by an operation similar to that which would be employed for pharyngotomy or œsophagotomy. In fact it will be a combination of these two operations. I will dissect through the tissues of the neck, until I come down to the pharynx and œsophagus, after which I intend to open these canals in such a way as to gain access to the posterior surface of the larynx. You can then see the movements of the glottis as they take place during the process of respiration.

I now make an incision extending from the angle of the lower jaw downwards along the track of the carotid artery to the lower part of the neck. I have now exposed, in the first place, the fibres of the platysma myoides. I cut through these fibres, which, in the dog, are very fully developed, forming a tolerably thick muscular layer, and then expose the external jugular vein. This vein also is very large in these animals, as compared with the internal jugular, in consequence of the great development of the external parts of the face, in comparison with the brain. I now place a ligature upon the anterior branch of this vein, which receives the facial vein, at the upper part of the wound, and turn it over forwards. A great many vessels usually require ligature in this operation, as the dissection is a very extensive one. I have now exposed the common carotid artery during a considerable part of its course, and will proceed to place a ligature upon it, so as to diminish as much as possible the supply of blood through its branches. We shall, however, still find a considerable amount of hemorrhage from the branches of the carotid as we proceed in our dissection, in consequence of the free inosculation which exists between the arterial branches on the two sides. You now see the superior laryngeal nerve. I will divide it, and you will observe that there is no visible muscular contraction produced, the crico-thyroid muscle, which is concealed from view, being the only one which is supplied by this branch. It now only remains, gentlemen, to secure the lingual artery, which runs across the upper angle of the wound, and to divide it together with the hypoglossal nerve which accompanies it.

I now raise the hyoid bone with the aid of a pointed hook, divide it with the bone forceps, and then cut through the walls of the pharynx continuing the incision downwards through the pharynx and œsophagus in this manner. Then we can turn the larynx forward, and expose in this way the opening of the glottis. We now have a clear view of the glottis, and as you watch its movements you will see that every time the chest expands the glottis opens, and when the chest collapses the glottis collapses also. At present the respiration is exceedingly quiescent; but in a few moments, when the respiratory movements will probably become more labored and active, you will see the movements of the glottis increase at the same time in rapidity and extent. You will observe also that so long as the animal makes no vocal sound the glottis is never completely closed, not even in prolonged expiration.

Now, I presume, as the animal appears to be gradually emerging from his etherized condition, we shall very soon see the movements of the glottis become more marked; and their characters are still more exaggerated whenever a vocal sound is produced. For in making a vocal sound you will observe that the vocal chords become tense at the moment of expiration, and the opening of the glottis is narrowed, by their approximation, to an almost imperceptible orifice.

I will now expose the two inferior laryngeal nerves, and divide them, one after the other, in such a way that we can appreciate the effect of their division upon the movements of the glottis. You perceive when the section of each nerve is made, that the corresponding side of the glottis is instantly paralysed. What is the consequence of this? Now, after division of both the nerves, as the animal inspires, you observe that these movements no longer take place. The inspiration consequently is difficult, the glottis no longer opening actively as before, and air therefore cannot gain a ready access into the chest. The only way of overcoming this difficulty would be to open the trachea below; for now the obstacle to respiration is not that the animal does not desire to breathe, but because it is impossible for him to do so owing to the mechanical obstruction of the glottis.

I will now break up the medulla oblongata, by introducing a steel instrument into the occipital foramen, and immediately all respiration ceases; not because there is any more complete mechanical obstacle to inspiration than before, but because the nervous centre being broken up, the reflex actions no longer take place which should result in the respiratory movements, and these movements, therefore, necessarily come to an end.

Original Communications.

DIFFICULT OBSTETRICAL CASES,

BY GEORGE T. ELLIOT, Jr, M.D.,

PHYSICIAN TO BELLEVUE HOSPITAL AND THE LYING-IN ASYLUM, CONSULTING PHYSICIAN TO THE NURSERY AND CHILD'S HOSPITAL.

(*Continued from page* 129.)*

CASE XXIII.—*Forceps—Tedious Labor from Rigidity—Safety of Mother and Child.*

Mrs. ——, Nov. 1860, aged 24, first labor; post. font. to right sac. il. syn. Male child living; mother did well; membranes ruptured at 4 A.M.; slight discharge of liquor amnii, and scarcely any more during the rest of the labor, which was one of the "dryest" that I ever saw. Tried injections of flaxseed tea, white of egg, lard, oil, glycerine. Vagina and perineum rigid and unyielding; chloroform for about ten hours to a moderate extent; pains very good; fœtal heart distinct. Sixteen hours after rupture of membranes I sent for a consultation, as the head had not changed its position for some hours. Post. font. now directed to right acetabulum. Professor Gilman saw the patient with me, and recommended forceps, which I applied. In this case the perineum was very rigid, and the anus widely open, as often happens in such primiparæ. In delivering her, which I happily succeeded in doing without the slightest laceration of the perineum, much assistance was gained by introducing occasionally two fingers well within the rectum, to make sure of the relations of the blades of the forceps to the fœtal head. It often happens, when the head of the child is seized obliquely, that the convex edge of one blade projects beyond the fœtal head, and if allowance be not made for this contingency in such a class of cases as this, the vagina may thus be lacerated or cut through while the operator is giving all due attention to the perineal fourchette, and to traction in the axes of the inferior strait. Indeed the accident is most likely to happen to the man who is making traction in exactly the right direction, for he thus presses the posterior vaginal wall most firmly with the free edge of the forceps blade. I have often received much assistance from this slight attention per rectum to the posterior vaginal wall, and I believe that lacerations of the vagina take place in forceps deliveries much more frequently than is generally supposed. An instance of laceration of the vagina, from exaggerated attention to another rule for forceps delivery, is given in the next case.

CASE XXIV.—*Forceps and Lacerations of the Vagina—Subsequent Forceps Delivery of a Living Child—Recovery of Mother.*

I was sent for in consultation to a multipara attended by two physicians, and reached the house a little before Dr. T. F. Cock, who had also been summoned. Fœtal heart beating, post. font. to right sac. il. syn. Forceps had been applied, but had failed to deliver. On each side of the vagina, opposite the junction of the pubic and ischiatic rami, were lacerations, evidently produced by pressing the forceps too firmly against these bones in an exaggerated side to side lever movement. I applied my forceps, and rotating the occiput to the pubes, delivered a living child. Mother subsequently did well. Chloroform.

This side to side movement is often very much exaggerated by gentlemen, who forget that a fulcrum ought not to be made of the soft tissues covering the bony pelvis.

If the recto-vaginal septum should be torn through, no time should be lost in sewing it up with metallic sutures. I reached Bellevue Hospital on one occasion just after one of the House Staff had lacerated this septum in a forceps delivery, and immediately sewed it up with silver wire; the septum healed, the perineum did not. It does not seem to me that the rule is imperative in cases of laceration of the perineum alone. I have been able to keep under observation for some years, and in subsequent labors, some cases in which the perineum has been lacerated down to the sphincter, and have been surprised at the restoration of parts even without systematic care or dressing. This, however, is one of the questions that will be settled within a few years.

CASE XXV.—*Forceps—Perforator—Impacted Head—Recovery of Mother.*

Saw a negress, in consultation with Dr. ——, in whose pelvis a large and well ossified fœtal head had become firmly fixed. Fœtal heart beating. Used all the traction that I could with forceps without advancing or moving the head one iota, when I perforated and delivered. This is certainly the most disagreeable duty in midwifery, but when the head is impacted in the pelvis, and where there is nothing left to anticipate but injury to the mother from delay, responsibility should be frankly assumed by any one who can conscientiously feel that he is capable of using, and has used, every alternative to prevent the result.

CASE XXVI.—*Tedious Labor—Ergot—Forceps—Child still born—Mother recovered.*

Mary Collin, aged 21, first. Jan. 1861. Duration of labor 56 hours. Still born male child weighing 8½ pounds, L. O. P. Dr. Page, House Physician, Bellevue. Eight hours before terminating the delivery I advised ergot, (vagina cool and moist, fœtal heart beating) as there had been no advance for many hours. Under its use marked progress was made, and at half past one, as there appeared a good likelihood of the delivery being terminated without instrumental interference, I decided to wait a few hours longer. At half past four, there was no fœtal heart, and the vaginal discharges were offensive and of an olive green color, while no further advance had been made. The cause of the delay was not very clear to me, but it is certain that the vagina was unusually small and unrelaxed. Having decided to apply forceps, I delivered, in presence of the House Staff, having to perform rotation and extension; and derived great assistance from examining the posterior vaginal wall through

* Vide also *New York Journal of Medicine* for Sept., 1856; Jan., May, Sept., 1857; March, July, Sept., Nov., 1858.

the rectum, as elsewhere recommended. Fourchette slightly lacerated. Chloroform. It would have been better to have delivered her with forceps before. In two recent cases, I have been very much pleased with the result of ergot. One at West Point, seen in consultation with Dr. Lent, responded happily to this drug—mother and child doing well. Another, seen in consultation with Dr. Lambert, progressed rapidly to a termination with safety to mother and child, after using ergot. In both cases the ergot was given, as in the case of Mary Collin, in order to save, if possible, an instrumental delivery.

Case XXVII.—*Deformed Pelvis—Dwarf—Forceps—Version—Still-born Child—Death of Mother from Puerperal Fever.*

Ellen Burnheimer—Bellevue—aged 29, first labor. Duration of labor, thirty-four hours. Female child—still born—weight seven pounds—L. O. A. Mother died seventeen hours afterwards from puerperal fever, then prevalent in Bellevue Hospital.

Forceps failing to draw the head through the contracted brim, I delivered by version. Chloroform.

Case XXVIII.—*Forceps for Febrile Symptoms in a Puerperal Fever Epidemic—Living Child—Death of Mother from Fever.*

Ellen Fagan—Bellevue Hospital. Dr. E. B. Barrett, House Physician. Waters discharged March 26th, 7½ P.M. At 10½ P.M. pains not very efficient, pulse going up, and vagina hot. I was sent for. Found the head just emerging in the superior strait, first position. Consulted with Dr. Barker, and delivered with forceps at half past twelve. Child living, male, weighing nine pounds. No laceration of perineum. Chloroform. Died on the ninth day from puerperal fever. Forceps decided upon in the hope of diminishing the risk from an epidemic of puerperal fever which then threatened all our patients. We have seen cases of natural labor in which the fatal symptoms have appeared before delivery.

In all cases of labor, excepting in primiparæ, I habitually give ergot after delivery of the placenta as a prophylactic against afterpains, and metritis, a practice which I have upheld for eight years. It seems to me most reasonable that the firmer the permanent uterine contraction the less the risks of uterine inflammation from the diminished amount of blood permitted to circulate in the uterus; the absence of decomposing clots and discharge in the cavity of the organ, and the contracted condition of the uterine sinuses as well through the uterine tissue, as near the mucous membrane.

Case XXIX.—*Forceps — Ante-partum Hæmorrhage—Mother and Child did well.*

Ann Martin, aged 25, third confinement, April 18th, 1852. Head presented, post. font. to left sac. il. syn—ten hours in labor—male child. Lying-in Asylum.

When the os commenced to dilate, hæmorrhage followed to about a handful of clots. Rotation delayed—tendency of occiput to sacrum. Chloroform. Fœtal heart beating slowly. I applied the forceps, and rotated the occiput in front. Child feeble, but rallied. Mother did well.

Case XXX.—*Twins—Forceps—Douche—One Child living—Mother did well.*

Bridget Fury, aged 24, second confinement, May 26th, 1853. Sixty hours in labor—first stage fifty-eight. First child presented the head, second position; weight six pounds; living. Second child, head first position; weight six pounds; living. Single placenta weighing two pounds. Lying-in Asylum. Os undilatable in spite of time and morphia. After thirty-six hours a half pailful of warm water injected within the os by Higginson's syringe. No effect. Subsequently a sound was promptly followed by pains and dilatation. Chloroform then for four hours, when I applied the forceps to the first child, and delivered with difficulty. Second child born readily. Mother did well.

Case XXXI.—*Deformed Pelvis—Forceps—Child Born Alive but did not Live—Mother did well.*

Rosa Keenan, aged 22, first labor. Head presentation, first position—duration seventy-two hours—female child, born alive, but did not survive—weight, seven pounds eight ounces. June 28, 1852.

In her childhood this patient dislocated the right femur on the dorsum of the ilium, and reduction was never effected. The true pelvis was unaffected except in the outlet, where the corresponding rami of the pubes and ischium were straighter than natural, and interposed a firm barrier to delivery. Twelve hours before delivery, I gave a full dose of ergot, and intended to call during the night to see the result. But I did not awaken until morning, when the nurse informed me that the pains had been so continuous and severe as to drive Rosa from her bed, and cause her to roll on the floor in agony. Fœtal heart unaffected. No progress. She was in the Lying-in Asylum, and I sent for Drs. Cheesman and Metcalfe, who arrived and decided to deliver with forceps. I could not introduce the second blade, and Dr. Cheesman carried it successfully to its position by at once placing it behind the right acetabulum. The deformity had prevented me from giving it the accustomed spiral sweep required from the fact that rotation had not been effected. The child was delivered with difficulty alive, but did not survive. This lesson, which I then learned (June 28, 1852), has been of service to me in a number of cases since that time. No chloroform given.

Case XXXII.—*Forceps—Peritonitis—Safety to Mother and Child.*

Dr. W. W. Jones sent for me to see this patient, and has kindly written the following history of the case.

"Mrs. E. C., 23 years of age, primipara, was taken in labor on the morning of November 30, 1859. During the day the pains were slight, but in the evening they became strong and regular. The head presented in the left occipito-anterior position. At twelve P.M., the os uteri was fully dilated; the membranes ruptured, and the head had descended nearly to the perineum. After this, though the pains were vigorous, there was no further advance. On searching for the cause of the delay, a firm tendinous band was found stretching across the upper part of the vagina, on the right side, which resisted any further advance, though the head was forced strongly against it with each pain. After some hours' delay, a vein was opened and a moderate amount of blood taken. *December* 1, 10 A.M.—The head remaining in the same position. Dr. Elliot saw the patient. Chloroform was given at once, and Dr. E. proceeded to deliver by the forceps. The blades were applied with great facility, but, though powerful traction was made, the head could not be moved. Dr. E. then withdrew the instrument, and reapplying it in a different position, rotated the head, and effected the delivery. The child was born asphyxiated, but by plunging it alternately into warm and cold water, and by artificial respiration, it was perfectly restored. Notwithstanding the force required in effecting the delivery, there was no abrasion, and hardly the slightest mark on the child's head or face. Immediately after the delivery a full dose of ergot was given, and the uterus contracted firmly. *December* 3.—To-day was taken with symptoms of peritonitis. Hydrarg. chlorid. mitis gr. x. with sulph. morph. gr. ¼ was given, followed by castor-oil, hot fomentations applied to abdomen, and, as soon as the bowels were moved, she was put on Magendie's sol. sulph. morph. gtt. x. every two hours, so as to produce narcotism—beef tea given freely.

This was continued until *December* 5, 10 A.M., when it was found that though the pain was relieved, and the respiration very much reduced below the natural frequency, the pulse had risen to one hundred and sixty beats per minute. She was then put on tinct. verat. vir. three drops, gradually increased to nine drops every three hours. This rapidly reduced the pulse, bringing it down in twelve hours below one hundred, and in twenty-four hours below sixty. As the effect of the morphine subsided, the pain returned, and it was found necessary to alternate the remedies. She was also early in the disease put on the use of stimulants.

December 8.—Patient materially improved, and on the 12th convalescent."

CASE XXXIII.—*Forceps—For Delay—Amylene.*

Eliza Douglas—Bellevue—Dr. Draper House Physician—aged 29, second confinement, labor commenced May 17, 1857, at six A.M., and was terminated on the 18th at eight P.M. Position R O.A. Before applying forceps ℥ iij. of amylene (all that I had with me) were given to the patient without successfully inducing anæsthesia; chloroform was then administered, and the patient promptly put to sleep, when I delivered a female child weighing between seven and eight pounds. The child did well, I believe—mother recovered.

This is the only case in which I have ever used amylene, its behavior in that instance not tempting me to experiment further.

CASE XXXIV.—*Forceps in Lingering Labor—Safety of Mother and Child.*

Dr. —— sent for me in consultation, in April, 1859, to Mrs. ——, a primipara, about twenty years of age, who had been in labor for two days, the membranes having been ruptured nearly thirty-six hours. The posterior fontanelle was to the left acetabulum, the movement of descent not completed, rotation unaffected, fœtal heart beating, vagina cool and moist, patient fatigued. The patient having been brought under the influence of chloroform by Dr. ——, I applied the forceps with the concavity of their pelvic curve to the left, rotated, and delivered a living female child of large size, which did well, as did also the mother. In this case an ineffectual effort at delivery with forceps had been made before my arrival.

CASE XXXV.—*Forceps for Rigidity—Safety for Mother and Child.*

Catharine Hallaran—first labor—forty-five years old, vertex—twenty-eight hours in labor. Delivered her with forceps of a living male child—chloroform. Mother believed to have done well. December 17th, 1852. Out patient of Lying-in Asylum.

CASE XXXVI.—*Head and Funis—Forceps—Living Child—Mother did well.*

Mary Loftus, third labor, aged twenty-nine. Head presentation complicated by prolapsed funis. She had been in labor five hours, when I delivered her with forceps of a living male child partially asphyxiated—chloroform. January 20th, 1854. Out-patient, Lying-in Asylum.

CASE XXXVII.—*Forceps for Rigid Perineum—Safety for Mother and Child.*

Ellen Brady—February 8th, 1854—first labor—thirty-two hours in labor. Head presentation R. O. A. Female child living. Forceps for rigid perineum and delay—chloroform. Mother believed to have done well. Out-patient, Lying-in Asylum.

These out-patients of the Asylum who are stated to have done well, according to the best of my belief are patients who did well as long as they continued under observation, and who would have probably sought advice if more had been needed.

CASE XXXVIII.—*Version for Transverse Presentation—Fracture of Right Arm—Forceps—Both did well.*

Kate Brown—Bellevue Hospital—second confinement—aged twenty-seven, fell in labor July 28th, 1859, at 8 A.M., under the care of Dr. Reuben Cobb, House Physician, who recognised a transverse presentation, left shoulder presenting, head in right iliac fossa. I arrived at half-past ten A.M., and the patient being under chloroform, delivered a living male child, weighing eight and a half pounds, by podalic version. The arms and head were retained above the brim, and I fractured the right arm in drawing it down. Manipulation of the head being unsatisfactory, I delivered promptly with forceps and saved the child. The fracture was treated, I believe, by Dr. George Johnson, now of Brooklyn, then one of the House Surgeons of the Hospital. I have never known an unsatisfactory result from the treatment of the fractured limb of a neonatus.

CASE XXXIX.—*Forceps for Deformity of Brim—Mother did well—Child's Face Lacerated—Died on Tenth Day from Erysipelas—History of former Labors.*

Mrs. ——, fourth confinement—January, 1859. No memorandum of the exact number of hours in labor, nor of the time when the waters escaped. By 3 A.M., however, the pains were strong and regular, and the os uteri fully dilated. 7 A.M.—No advance except of the caput succedaneum—head retained by the brim. Ergot given until it produced its characteristic pains. 8 A.M.—No progress. Vagina, which had been cool and moist at five A.M., now becoming hot and dry. I was then called and recommended forceps, which the physician in attendance applied after chloroform had been given, and made powerful traction until they slipped. As he was suffering from a severe sick headache, which was greatly increased by his efforts at traction, he requested me to deliver, and I re-applied the forceps exactly as he had applied them before, and with great difficulty drew the head through the brim, rotated the occiput in front and delivered a living child, with a laceration upon the cheek midway between the eye and the mouth, about an inch long, produced by the point of the corresponding blade. This was brought together with silver wire at once, but the child died on the tenth day from erysipelas, which unfortunately attacked the face, and was aggravated by neglect of the parents to feed the child properly, the mother having no milk at all. She made a good recovery. My forceps were used. The cause of delay was diminution of the ant. post. diameter of the brim by projection of promontory. In the first labor I delivered a living child with forceps, with the left parietal bone so deeply indented by the promontory as to allow more than one finger to be laid therein. Dr. Isaacs gave chloroform—child now living; no trace of the depression. The second child presented the breech, and I arrived when the body was born and the child dead. Chin in front to the right. Dr. Gouley gave chloroform, and I rotated the chin posteriorly with forceps and delivered. The third child was smaller, and withholding chloroform—for which she begged piteously—I succeeded, with ergot, in driving a living child through the contracted brim. In the present instance no such favorable result was to be anticipated, the full force of uterine contractions, stimulated by ergot, having only increased the caput succedaneum and not advanced the cranium.

TREATMENT OF FRACTURES OF LONG BONES BY SIMPLE EXTENSION.

A PAPER READ BEFORE THE MEDICAL SOCIETY OF THE STATE OF NEW YORK, FEBRUARY 6, 1861.

BY JOHN SWINBURNE, M.D.,
OF ALBANY.

AT the annual meeting of the Medical Society of the State of New York, for the year 1859, I gave my experience in the treatment of fractures of the femur by simple extension, and related the histories of twenty-five cases, which, in my hands, had resulted better, with more rapid recoveries, and more comfort to the patient, than I had been able to attain by any other means. I now propose to show that the same method can be applied to the treatment of fractures of all the long bones with equal success; and also that splints *per se* are useless, and in many instances worse than useless, if not absolutely injurious, except they are used as a medium by which the muscles are kept on the stretch.

I will endeavor to show from actual experience, first, that the practical surgeon requires no appliances for the treatment of fractures of any of the long bones, except such as are extemporaneously made; second, that the same can be said of the treatment of fractures occurring in, or in close

proximity to any joint, such as intra-capsular fracture of the neck of the femur, Colles' fracture of the radius, those involving the elbow-joint, the surgical neck of the humerus, compound dislocation and fracture of the ankle-joint, compound fracture of the tibia and fibula, etc.; thirdly, that the same is true of diseased hip-joint, morbus coxarius, also incipient knee-joint disease. These several points I shall discuss separately, as well as the principles involved in the procedure.

I would ask of what service is a splint or splints? What office do they perform in the treatment of fractures? Authors say, they support the bone while union is being effected. I would ask, how many fractures of the long bones can be placed in apposition without the *use of extension*, particularly in oblique fractures, or where there has been great injury to soft parts, and overlapping of the bones? I know of few exceptions. The true use of splints *should* be to keep the fractured ends of the bone in apposition, by placing the muscles on the stretch, and thereby making them (the muscles) the true splints. The experiments of Reid and others show, that muscles are not susceptible of being stretched beyond their normal capacity; that when so stretched, they are capable of bearing great lateral pressure without much deflection; and any attempt at undue lateral pressure results in rupture of the muscular substance.

The supporting power of the muscles may be pretty well illustrated by the following experiment: Take a strip of wood, and encircle it lengthwise with a number of cords of catgut or other strong fibre. Fasten these cords to two pieces of board, and then, by drawing these boards strongly apart, render the cords tense. The cords represent muscles; the strip of wood, bone; and the tightening of the cords, extension and counter-extension. While the investing cords are in this tense condition, endeavor to bend the strip of wood, when it will be found that the deflection is very slight, and that fracture of the stick is impossible. Replace this strip of wood with one broken through the centre, endeavor to bend it while the cords are tense, and the deflection in this case will also be very slight. To carry out the analogy still further, let the cords be attached to the ends of the strip of wood, as the muscles are virtually at the ends of a bone. Now, if the fractured ends happen to be square (representing a transverse fracture of bone), they will be in apposition while the cords are made tense, but when the tension is relaxed the stick is no longer straight, and it bends to one side or the other as the case may be. Now, represent an oblique fracture of bone, by cutting the fractured ends of the stick to any angle, oblique or acute; while the cords are stretched by extension the ends lie in juxtaposition, but when the extension is relaxed, the ends slide past each other, and lie at rest, side by side, in the only position possible for them. Suppose this broken stick, instead of being enveloped by simple threads, was covered with muscles put upon the stretch, and bound laterally by strong investing fascial and cellular tissue, the interstices of which are filled up with fat and invested by the skin, so as to combine the separate parts in one whole, you would have then, I apprehend, splints more permanent, unyielding, and enduring than any artificial appliances. How is it, for instance, where nature is left to herself, without any mechanical appliances? The bone unites, and that too without any bandages or lateral pressure, though with more or less deformity. But it unites, notwithstanding the motion which takes place almost hourly.

All that nature requires for perfect union of bone is *rest* and a moderate degree of excited action, while all pressure by splints, bandages, etc., only impedes the process of reparation; and this pressure, in my humble opinion, is a prolific cause of non-union, as I will endeavor to demonstrate hereafter. While nature requires rest for bony union, she requires also *perfect apposition* for union without deformity. How is apposition to be effected? We start with the knowledge that a muscle cannot be extended beyond its normal capacity, and that any attempt to go beyond this not only provokes resistance, but a tearing of the muscle. Take, for instance, a fractured thigh; extension on the extremity, by a strong man, will stretch the muscles to their normal length only, which fact can be shown by the most careful measurement, thus proving that the danger of *too much* extension is only imaginary. With the muscles drawn out to their natural state, what becomes of the bone? Where can it go, if not to its normal position, with the fractured ends in contact?

Let any one take the cadaver, dissect out cleanly and carefully all the muscles of any long bone, leaving all their attachments entire, and after fracturing the bone at any part, make extension. He will find that the fractured ends assume their normal position. Would they not equally do so in the living subject, where muscles are invested with skin, fat, fasciæ, cellular tissue, and vessels?

Again, assuming the position that the extended muscles act as permanent adjusters of broken bones, and are in reality the only means by which the fracture is maintained in apposition, I ask of what use are all the mechanical appliances and apparatus, called surgical *splints*, if not to effect the above-named results? The splint beyond this possesses no practical worth; on the contrary, it is apt, by its too careful adjustment, to impede the reparative process, by interfering with the proper circulation of the part. It is for *this* reason that some surgeons make it a point to apply emollient dressings until the inflammation and the swelling subside. Even this delay is far preferable to the immediate application of carefully adjusted splints, bandages, etc., particularly where there is much contusion of the soft tissue, either from the bone within, or externally from the forces by which it was broken. Take, for example, two limbs equally contused, the sharp edges of the broken bone goring the muscles and nerves, the cellular tissue filled to repletion with blood, and the slightest movement causing the most excruciating pain. Subject one of these to simple extension, without any incumbrance to the broken member, such as splints or bandages, apply simple warm water dressings, and in a few minutes the patient is easy and comfortable, and remains so as long as the extension is kept up. Let the other limb be adjusted by the most careful and approved surgical appliances (unless these are such as keep up the extension without bandages or compression), and there will be a marked difference between the two in the degree of comfort experienced.

Then we may say that in extension the muscles and other investments of the bone are the true splints, and that there is but little exception to this principle being universally applicable. Surgeons situated in remote parts of the country have to act and not originate. They see comparatively few cases of surgery, and are the possessors of fewer instruments and surgical appliances. They may be called a number of miles to see a patient, and find, when they arrive at the house, that the appliances which they are in possession of do not answer the purpose. What are they to do? Send for some one at any distance, thereby wasting much time and entailing much unnecessary suffering? If we can treat any fracture occurring in the leg or thigh, from the hip to the foot, simply by a perineal belt and extension from the foot, without any splints, and make better results, with more comfort to the patient, and with more speedy recovery of the use of the limb, we have surely arrived at the grand desideratum; and when the treatment of fracture of the arm or forearm is rendered equally as simple, we have, I apprehend, arrived at the *ultima Thule*. As for myself, I employ this treatment indiscriminately, and I only ask my professional brethren, who have the opportunity to *try* it, to do the same, and I am sure they will be able and willing cheerfully to bear witness to its entire efficiency, as have my friends Drs. Thorn, of Troy; McLean, of the Marshall Infirmary; Whitbeck, of West Troy; and Willard, of this city. I am positive that the method will withstand the most searching tests, and that it challenges comparison with the results of the most complex machinery of splints and bandages.

I have now treated over forty fractures of the femur and tibia, and in no instance have I seen over half an inch shortening (and that was the result of inattention), while in the larger majority there was no shortening at all (this, of course, does not include inter-capsular fractures, where there is always more or less deformity), nor were there any of these that resulted in a non-union. The only case of non-union of the femur that has occurred in this city, to my knowledge, was that of a boy of about eighteen years, of good habits and enjoying good health. By some accident he broke the humerus and femur. The former was treated with the ordinary splint, and recovered in a reasonable period, while the latter was fastened to the bed by the perineal belt and kept upon extension for some days. After this (the surgeon not having full confidence in simple extension), thinking to make the treatment doubly sure, made use of a Liston splint in addition. Thus while "trying to serve two masters" he failed in effecting union of the limb, and, though nearly two years have elapsed, it still remains ununited.

In fractures of the tibia I have seen no patients suffering from non-union, where extension was applied. But I have had three that failed to unite for three to five months, and they united only by bandaging and splints, and allowing the patient to go about and use his limb moderately, thereby creating some excited action. Of the humerus, radius, and ulna, I have seen no cases of non-union occurring in this city.

In my opinion, one of the prolific sources of non-union is the action of the muscles (spasmodic or otherwise) in causing the overlapping of the ends of the bone. I do not agree with the suggestion lately advanced, that non-union of the humerus might be due to a separation of its broken fragments. Is it true that the bone separates after hanging some time? I answer no! Instead of separating, it overlaps, and extension is absolutely requisite in order that it may be placed in apposition. The biceps and triceps are too powerful to relax in that way, particularly when under the influence of excited and inflammatory action. Overlapping of the bone has been suggested as a cause of non-union. Let us see a little what takes place when a bone is broken. 1st. You have the muscles gored and irritated; and the result is contraction of the muscles to their fullest extent. 2d. More or less overlapping of the bone. 3d. Infiltration of blood in the tissues. 4th. Muscles inflamed and hardened. This is the first stage. Now if this condition is left alone, ossific matter is thrown out, and union takes place, but with a shortened bone. If, on the other hand, you bandage and splint this limb, the parts are compressed; absorption goes on, and with it the ossific deposit is either prevented from forming, or is slowly taken up; the muscles are agglutinated to the surrounding tissues; and union is thereby needlessly impeded or wholly prevented, making the process of restoration exceedingly tedious. This also constitutes another one of the causes of non-union in healthy subjects. In my experience extension without splints has never resulted in non-union, notwithstanding over one hundred cases of fractures of the various long bones had been treated by that method, while out of only twenty or thirty cases treated by splints I have seen temporary non-union result in three instances.

In fractures of the inferior extremities, the patient, of necessity, is obliged to keep his bed, and hence there is less demand for comely appliances than in cases of fracture of the arm or forearm. In fracture of the femur, I use simply extension and counter-extension without splints, and in the leg I sometimes do the same. At other times I effect extension and counter-extension through the medium of a delicate splint, and an equally delicate foot piece fastened to the foot by means of strips of adhesive plaster, while the counter-extension is made from the knee by adhesive plaster looped about the limb below the joint. Then, by means of a strong cord passed through this loop, and thence through a hole in the side splint some distance above the knee, the requisite extension can easily be made to any desired degree. If, after full extension is effected, it should appear that the limb is not sufficiently steady at the seat of the fracture, the application of strips of plaster around the limb and splint, at intervals of three or four inches, will accomplish all the indications. If the fracture of the leg happens to be near the knee-joint, I am in the habit of using the perineal belt, made large, full, and easy, as in fracture of the thigh.

In compound fractures of the tibia and fibula, extension is especially applicable, and I may say indispensable. And here, to forestall any objections to this method, arising from the fact of a constant tendency on the part of the superior fragment of the tibia to anterior displacement, in consequence of the powerful contractions of the gastrocnemius and soleus muscles, I remind you of four artifices, either of which, according to the preference of the surgeon, or the particular exigencies of the case, will be certainly effectual in conjunction with extension and counter-extension, in preventing this deformity. 1. The use of the double inclined plane, with a view of subduing the contractions of the strong posterior muscles. 2. The judicious application of adhesive strips around the extending splint and limb, after inflammation has subsided. 3. The insertion of stout silver wire through small holes drilled into the fragments, and bringing these into apposition by twisting. 4. Malgaigne's steel point apparatus.

In simple or compound fracture of the ankle-joint, with dislocation, there is, from the same causes, more or less disposition to displacement, and consequent shortening. Here we are obliged to pursue a different course of treatment. The injury to the bone and soft parts is, in such cases, in so close proximity to the dressing used for extension, that for some few days we can do but little good by any attempt to extend the parts to any considerable degree, while, on the contrary, much mischief may ensue from inflammation, &c. The same condition applies to the use of bandaging and splints.

Taking into account all these conditions, I am in the habit of using the same kind of apparatus as above described for compound fracture of the tibia and fibula, and also flexing the leg on the thigh by means of pillows placed in the popliteal region, thus creating a sort of double inclined plane, and effectually relaxing the gastrocnemius and soleus muscles, which is an essential element in this form of displacement.

The fractures of the superior extremities are subject to the same laws, and hence require the application of the same principles. But, owing to the fact that the patient is not confined to the bed, the extension and counter-extension are necessarily made through the medium of a splint, while, in the lower extremities, the *bed* is the splint, the foot of the bedstead the point of extension, and the headpiece the counter-extending point.

In fracture of the humerus through any portion of the shaft, simple extension can be made by having a splint extending three inches below the elbow and the same distance above the shoulder. The elbow is secured to the lower part of the strip of board by means of adhesive plaster passed through a fenestrum, while to its upper extremity it has fastened the extremities of an axillary belt. We are thus enabled to obtain full extension and counter-extension with comparative ease and comfort to the patient, the muscles making the only true splints. The arm is kept in a sling, and if the surgeon feels any uneasiness as to the disposition of the bone, he can place a strip of adhesive plaster loosely at short intervals about the arm and splint, so as to prevent any kind of lateral motion in the parts.

In the treatment of fractures through the shaft of the radius, or radius and ulna, I use a simple splint situated on the posterior part of the forearm, fastened at the bend of the flexed arm by adhesive plaster, and the other end to the wrist by the same method, so that you get extension of the muscles to their normal condition, and also by this means approximate the ends of the bones. But inasmuch as the

line of extension is not direct, and the bone is disposed to bow forwards, a few strips of adhesive plaster applied loosely around the arm and splint, at intervals of two or three inches, will keep the line of the bones correct.

Colles' fracture, which consists in fracture of the radius near the carpus, and dislocation of the ulna, presents one of the most troublesome forms of fracture that the surgeon is called upon to treat. This last appliance has in my hands been very successful in the treatment of this accident, though I am obliged to use a compress in the concavity of the wrist in order to give the ulna sufficient posterior prominence.

I see by a reference to the journals, that a splint devised by Dr. Geo. F. Shrady, of New York, is applied with great success in the treatment of this form of fracture, thereby obviating the so-called "silver-fork" deformity. Although the principle of extension and counter-extension by Dr. Shrady's plan is similar to that which I recommend, and the peculiar flexed and adducted position in which he places the hand is sufficient to maintain the fractured ends in apposition, I would, however, say, in relation to the splint, that in the first place it is not always at hand; 2d, its results *can* be no better than those obtained by the simple method of treatment by a shingle, piece of cigar-box, or any other piece of thin board by which to keep up the extension and counter-extension. I have now treated seven cases with the best possible results by my method, and they will bear comparison with those treated by any other. In fact, they are as perfect as they were before the accident. The fractures managed thus are nearly painless; and none of them have required redressing during three weeks of treatment, except an occasional addition of a new adhesive strip to perpetuate the extension. There is so little incumbrance about the limb that it can be examined without disturbing the dressings, while there is no swelling from tight bandaging, and the application of warm or cold water does not disarrange the dressings.

The most important forms of fractures are those situated near, and involving the elbow-joint, either of the bones of the forearm or arm. In this position, extension by direct means would be inadmissible for several reasons; the least important one being the awkward position of the arm for comfort to the patient. The plan I propose is simple, the apparatus easy of manufacture, while the extension and counter-extension is effected by simply flexing the forearm at right angles with the arm, and maintaining it in this position—thus effecting all the required conditions for a perfect apposition. The instrument is made by taking two pieces of thin board, one-quarter inch thick, fastened at the bend of the elbow by a hinge two inches wide, the lower portion extending from the elbow to the ends of the fingers, or even two inches below; the short portion extending from the elbow to the shoulder, terminating in a crutch for counter-extension; or the same end can be attained by fastening the upper end of the splint to the arm by means of adhesive plaster with the arm in an extended position. The lower end of the splint is fixed to the hand and fingers with adhesive plaster, the other to the arm by the same means, or to the axilla by a crutch. Now, flex the forearm upon the arm, and you will produce from one to two inches of extension, depending upon the diameter of the arm. This form of dressing is especially applicable to fracture of the ulna and dislocation of the humeral portion of the radius, fracture of the humerus through the olecranon and coronoid processes, and where the fragment is displaced with the ulna. The complication of displacement of the head of the radius, or even fracture of this bone, will not alter this mode of procedure.

In treatment of fractured clavicle through any portion of it, or in fracture of the coracoid process of the scapula, the common treatment has always been to draw the shoulders backwards, and thereby apply this principle to its fullest extent without any appliances of adjustive splints, and who ever failed to obtain union of the cavicle? The plan I have adopted with success, and particularly in children, is to overlap their clothes in the back and pin them firmly in that position. I have found a strong waistcoat closed in front answer a very good purpose for the adult, pinned or laced up behind, thereby effecting all the requisite ends without the annoyance of wearing all mechanical appliances made and applied *secundum artem*. In this way patients go about with all their clothes in position, as if nothing serious had happened. If a portion of the bone should become prominent, I am in the habit of using strips of adhesive plaster, drawn tightly over the projecting fragment, and thereby keeping it in its proper place.

Reports of Hospitals.

UNIVERSITY MEDICAL COLLEGE.

PROF. JOHN T. METCALFE'S CLINIC.

Two Cases of Angina Pectoris, with Valvular Disease of the Heart.

Case I.—Sarah Madden, æt. 50, Irish, married, a large, stout, well developed, and healthy looking woman. There was not the slightest appearance of disease discoverable by mere inspection. She had descended from a healthy parentage, though both father and mother were dead. She, with the exception of an attack of typhus, had been healthy. She had passed the change of life one year previously. During the whole life, the menstrual flow had been very regular but quite profuse. The commencement of her present illness dates seven years back. It consisted of a severe pain in the epigastrium, extending up into the throat and down through the left arm to the wrist. This, in the beginning, had never been severe enough to prevent her working, until within the last two weeks. Her trouble had sensibly increased since the change of life. Within two weeks, in addition to this constant pain, she had suffered from a sense of choking, loss of breath, and impending death. These attacks were severe but paroxysmal, there being intermissions of a half hour more or less, as exercise was taken. This was the exciting cause. In all other respects she was perfectly well. The appetite was good, digestion normal, bowels regular. There was no head trouble, urinary disease, or cough.

Physical signs.—Respiration twenty-five per minute; pulse even, full, large, and strong, one hundred and four per minute. There was visible arterial pulsation. There was a distinct thrill perceptible in the præcordium. Also an abnormal impulse of the heart. Dulness commencing with the third rib; extent indeterminate from the thickness of the mamma. At the base of the heart there was a double, coarse rough murmur, transmitted along the principal arteries.

Diagnosis.—Permanent patency of the aortic valves and hypertrophy of the heart, producing angina pectoris.

Enough has been told us, without physical examination, to give us the hint. She has angina pectoris. The pain in the epigastrium, extending up into the throat and down the left arm, together with this sense of choking and impending death, is sufficient evidence of this. Angina pectoris is attendant upon almost every variety of heart disease, hypertrophy, valvular disease, and fatty degeneration. In this case we find by physical signs that there is permanent patency of the aortic valves with hypertrophy of the heart. These lesions are quite sufficient to explain the angina. You remember what I have told you as to the pathology of the valves. The opening into the aorta is constricted and the valves are broken down, so that the current of blood, in going through the artery, is impeded, and is not prevented from regurgitating. This disease is confined almost entirely to males. Recollect this case as one of long standing, and yet that there had been no dropsy. The reason for this is, that she has hypertrophy

of the heart. This is almost the only case in our clinic where cardiac diseases of such long standing had not caused dropsy. The prognosis is unfavorable. The course of the disease is probably short.

Treatment.—She must avoid all excitement and exercise, anything which may accelerate the heart's action. For this pain a belladona plaster would be very comforting. Aside from this give her general treatment.

Case II.—Moses Bulgion, æt. 52, a single man, born in Ireland. Patient's general health had been uninterruptedly good. Beyond suffering from chronic, wandering, rheumatic pains for fifteen years, he is perfectly well. His present illness commenced one week before Christmas. His only symptoms, according to his own account of himself, were, loss of appetite and pain in the chest. This pain was peculiar, being located immediately beneath the centre of the sternum; constant, but not at all times very severe. Sometimes it was aggravated into paroxysms. These paroxysms usually came on either during sleep, or as he was going to sleep. He had been in bed more or less every day since he was taken; had been treated by mustard plasters and blisters, and had taken enemata for constipation. He comes for advice with reference to the pain, which is his principal complaint. Besides the pain in the chest, he refers to a pain in his stomach after eating. His food felt like a weight within him. His bowels were constipated. He had no cough, no dyspnœa; no emaciation.

Physical Examination.—The patient's chest was well formed, the resonance over both lungs was excellent. There was no increase of præcordial dulness. The apex of the heart was in its normal position. At the base of the heart there was heard a murmur, double, very faint with the first sound, and heard distinctly with the second. This was heard less clearly at the centre of the heart, but clearly along the blood-vessels.

Diagnosis.—Angina pectoris and disease of the aortic valves.

Remarks.—Let us first make out a *rational* diagnosis, if possible; let us seek the causes which may produce this pain. We may have pericarditis, endocarditis possibly, angina pectoris, and lastly aneurism, producing this pain of which the patient complains. Pericarditis runs its course in less time than six weeks, and if this man has had it we should find either an effusion into the pericardium, or a glueing together of the opposed surfaces of pericardial sack. If this man has had Pericarditis, if he has effusion we should find increased extent of the pericardial dulness, and a muffling of the heart sounds, from the layer of fluid interposed between the heart and the ear of the auscultator. If he had a glueing together of the opposite surfaces of the pericardium, we might find a wrinkling of the abdominal walls, coming and going with the beating of the heart, the reflex layer of the pericardium being attached to the diaphragm, and now firmly fixed to the heart, would explain the reason for this. Aneurism of the arch of the aorta might, by pressure upon the nerves of this region, cause much pain, but with this we should expect some affection of the larynx, and should have circumscribed dulness, marking the position of the tumor. Endocarditis or valvular disease exists here. The physical signs reveal it, and it has probably existed longer than since Christmas, though it did not give rise to this agonizing pain, which is a distinct thing. You have here a murmur with both sounds of the heart, but the first is so indistinct that we will disregard it. As the murmurs are heard along the vessels going away from the heart, we know the disease must be located in the aortic, and not mitral valve. Besides, we very rarely have a murmur with the second sound of the heart, which is connected with the mitral valve. Dr. Walshe, who has perhaps seen more chest disease than any other living man, says he has never met this form of disease. Dr. Latham who, perhaps, is second to Dr. Walshe, says the same. The best and most experienced auscultators in this city say that they have never seen more than one or two cases of it. This pain is what we call angina pectoris, which is a very unmeaning word, and it is applied to many different things. Some consider it to be a neuralgia of the heart, others a muscular rheumatism. Others still think it a disease which accompanies ossification of the coronary arteries. I consider it to be heart pain. Dr. Walshe says that it may exist with any form of cardiac disease. From his history of chronic rheumatic pains, and especially from the physical signs, we recognise this to be a case of endocarditis—valvular disease of the heart as it is usually termed. The condition of things is simply this: the aortic valves are not perfect so as to prevent regurgitation of blood from the aorta back into the ventricles. It of course distends this cavity. It distends the auricle also, and often the pulmonary veins and lungs, producing the most urgent dyspnœa. This symptom is wanting here, probably on account of the integrity of the mitral valve. From this distension of the heart's cavities, and contraction of the heart upon its contents, we have this most agonizing pain. But, after all, may not gastric disturbance cause this trouble? You know that disease of either heart or stomach will affect the other organ. There is no tenderness in the epigastrium here, and all his indigestion may be explained by the cardiac trouble. There is nothing peculiar in this case. The disease is of long standing, and shows no disposition to go away. It will probably last for life, and carry him off at last.

Treatment—This must be entirely palliative. He has been well treated by counter irritation. You can see that during the paroxysms caused by the stagnation of blood in the heart, if the patient could bear it, the abstraction of a small quantity of blood would relieve him. As it is, we can prescribe nothing better than counter-irritation and narcotic applications. A belladonna or stramonium plaster, as in the other case, placed over the præcordium would be very good. This will quiet restlessness and soothe the pain. Our treatment must be purely palliative. We cannot cure organic disease of the heart.

American Medical Times.

SATURDAY, MARCH 2, 1861.

SCURVY IN THE ARMY.

Two thousand eight hundred and three cases of Scurvy were reported as occurring in the little army of the United States, for five years, ending on the 31st of December, 1859.

Two thousand eight hundred and three cases in five years in an army of an average strength of less than 14,000 men!!! Can such things be? Were this statement based on common rumor, or newspaper correspondence, we might receive it with incredulity. But if the reader will refer to the *Medical Statistics of the United States Army*, recently published, he will find, on page 324, the figures which substantiate this assertion. This information comes to us, therefore, with the full endorsement of an official report, and is to be treated as an established fact.

To find some fit data wherewith to institute comparisons regarding the appearance of scurvy among other bodies of men, not soldiers, we have the privilege of referring to a letter from W. N. Belcher, M.D., Physician to the State Prison at Sing Sing, New York, containing information as to the frequency of scurvy among the convicts of that Institution. It appears, that in an approximate estimate of an average force of 1000 convicts, there have occurred

fewer than fifty cases of scurvy during the last five years! Can we contemplate this difference and be satisfied with the astounding preponderance of such cases in our army? This preponderance—even admitting the occasional re-entrance of the same case for treatment, which not unfrequently occurs—is greater than it would seem at first. No man is allowed to be enlisted in the army of the United States whose health, constitution, and powers of endurance are in the least degree doubtful. None but *picked* men are enlisted, and these are not assigned to companies until they have gone through the ordeal of three physical examinations, by different sets of medical officers. The greater number of these men serve but for five years, when, being discharged, their places are filled with fresh, healthy recruits. The convicts at Sing Sing, on the contrary, are composed of men of all ages, and of every corporeal condition. The broken-down drunkard, the aged, the infirm, and those suffering from all the evils of vice, are there gathered together. The fact that the prisoner's sanitary condition is below *par*, is no bar to his admission; the simple test of the convict's fitness for the place being his guilt.

It is not our purpose to enter upon the history and treatment of scurvy. In several *minor* particulars medical men disagree as to its *exciting* causes among troops. Some believe that excessive guard duty, exposure to wet, etc., are the leading *immediate* causes of its appearance; others, that added to the above, depression of spirits, home sickness, and want of amusement, are important excitants. It matters little what are the *excitants* (nearly all of which, by the way, exist in an exaggerated form in our prisons), the predisposing cause remains the same.

During the late mutiny in India the British press was exercised to find out the real cause of the rebellion. Some attributed it to the "greased cartridges," which the Sepoys were to use in defiance of their religious prejudices. Others spoke of a variety of sources of active irritation, to which they gave full weight. But it was apparent to those not specially interested in this controversy, that the people must have been ripe for rebellion, and the troops for mutiny, long before the greased cartridges were thought of, and that the real great cause of the Indian mutiny was simply the bitter *hatred* existing in the minds of the natives towards the English—hatred hitherto slumbering and quiet, but not the less intense; produced in any way you will, yet covered by the theory of the *antagonism of distinct races, when brought together on the same soil.* Had this antagonism and hatred not existed, the greased cartridge would not have been the spark which caused the explosion. Thus it is with scurvy. Professional men attempt to assign causes for its appearance, which are merely exciting, forgetting that great *sine quâ non*, THE ABSENCE OF FRESH VEGETABLE FOOD IN SUFFICIENT QUANTITY. This is sufficiently well known to all classes of men, whether in the medical profession or not, to do away with *ignorance* as an excuse. The man who ignores the necessity of supplying bodies of men with the needed amount of fresh vegetables, or in default of these, with ample supplies of desiccated vegetables, and other well known anti-scorbutics, is unfit to command an army. In scurvy, perhaps more than in any other disease, is the old adage true, that "an ounce of prevention is worth a pound of cure." But the late *economical* Secretary of War, John B. Floyd, appears to have thought differently. If any one doubts this, let him read the following General Order, issued by the Adjutant General:—

GENERAL ORDERS, No. 3.

WAR DEPARTMENT, ADJUTANT GENERAL'S OFFICE, *Washington, March 4, 1859.*

The following regulations have been received from the War Department, and are published for the information and government of all concerned:

1st. Purchases by the Subsistence Department of "Pickles," "Sour Krout," "Dried Fruits," and "Fresh Vegetables," unless for the sick in hospital, are prohibited for the future.

2d. Two "Issues" per week of "Desiccated Vegetables" may be made *in lieu* of "Beans" or "Rice."

3d. When "Fresh Beef" can be procured at 6¼ cents, or less, per pound, net weight, it will be issued to the troops five times per week.

BY ORDER OF THE SECRETARY OF WAR.

Of the disastrous effect of this General order we are furnished with an instance, by a medical friend, who, in 1859, acted as Medical officer to a large military command, moving from Fort Leavenworth to Salt Lake. For 900 miles the troops were provided with no vegetable anti-scorbutic, except a few insipid desiccated vegetables. Scurvy began to show itself. Application was made for pickles to be issued to the men. The reply was, that the commissary had no pickles! "Buy them of the traders and sutlers," was the surgeon's reply. The commissary answered, and as a military man, very properly, "Doctor, General Order No. 3 forbids me to purchase them." The men were thus deprived of proper food, and scurvy was not slow in manifesting itself. During the term of years the statistics of which we have just quoted, the cost of maintaining our army amounted to fully seventy-five millions of dollars. Compared to the various rates paid for the transportation of everything in the remote wilds of the West, the *economy* evinced by General Order No. 3, of March 4, 1859, was pitiful, scandalous, shameful, and inhuman; and seems as if intended for effect. We leave it to political journals to discuss "flour contracts," &c., but in the name of humanity we protest, as medical men, against such orders as that we copy.

The "penny wise, pound foolish" manner in which our army matters are conducted is frequently the result of circumstances inherent in all such organizations. Yet it is "never too late to mend." Report upon report has been written by the medical officers, recommending sanitary improvements for the prevention of scurvy, and to improve the hygiene of the army. In most instances it was like "talking to the wind." Anything for the real good of the army has been ignored; but much encouragement has been given to the patentees of new inventions, who have political friends or long pockets.

Nothing in this communication is meant to reflect upon the character of the *officers* of the army. From Lieut.-General Scott down, they are generally gentlemen, who, to their credit be it spoken, deplore the evils herein assailed. But to the charge of irresponsible Secretaries of War, much of the disgrace of this state of things must be placed.

The late Secretary, with the soft words, "I have the honor to transmit," laid before Congress this official report, charged with facts the most discreditable to his department. May we hope that long will be the time and far distant

the day when convicts shall be better treated than soldiers, and another Secretary of War will have the "honor to transmit" a report acknowledging the occurrence of two thousand eight hundred and three cases of scurvy.

THE WEEK.

It is gratifying to notice the growing interest felt in Sanitary Reform in this country. Much of this is due to the impulse given by the meetings of the National Sanitary Association. The Sanitary Association of New York was the first local organization, and it has already done a great work for our city. True, our Health Department has not been improved, but a public sentiment has at length been created, which now gives unmistakable evidence of its power and its purpose to sweep away the corrupt and inefficient department which has for years disgraced New York, and reconstruct a thoroughly scientific sanitary system. The Association numbers its members by hundreds, many of whom are prominent citizens. The citizens of Brooklyn soon after organized a Sanitary Association, and recently we notice that a similar society has been instituted in Boston, under the Presidency of John Ware, M.D. Finally, a Sanitary Society is about to be organized in Philadelphia. These societies should exist in every town throughout the entire country, in order to the study of the means of increasing the salubrity of towns, the investigation of the causes of epidemic and endemic diseases, the improvement of the sanitary condition of schools, churches, and dwellings, and the diffusion of knowledge relating to the social and physical well-being of the people.

A strong effort is being made in this city, to secure the appointment of competent and efficient officers to administer the Drug Law. Committees have been appointed by the various medical societies and the College of Pharmacy, which have held joint meetings for the purpose of uniting their efforts in influencing the incoming administration to compel the candidates for these positions to undergo a thorough scrutiny as to their qualifications.

Another instance of the death of a physician by the communication of the diphtheritic virus from the patient is reported. The French Journals state that Dr. Gendron, of Tours, while attending a woman suffering from croup, had his face covered with the expectorated matter, while the patient was undergoing the operation of tracheotomy. He was very fearful of this attack which promptly occurred, and of which he died. It will be remembered that the lamented Dr. Charles Frick, of Baltimore, lost his life in a similar manner, being attacked with diphtheria soon after performing tracheotomy on a patient dying of that disease.

New York Ophthalmic Hospital.—The Annual Commencement of this institution was held on Monday evening in the Fourteenth-street Medical College, in the presence of a large number of students and medical men. Peter Cooper occupied the chair. Dr. Stephenson, the President of the Faculty, made a few preliminary remarks in regard to the organization and success of the institution, and concluded by awarding testimonials to the following gentlemen, who composed the graduating class. James Cray, George W. Edwards, Cornelius F. Miesse, B. A. Watson. A. J. Harris, G. T. H. Scott, W. L. Wheeler, Max Goldbacher, F. G. Stanley, Henry Hill, S. Souders, S. W. Briggs, J. L. Kiernan, Charles Hait, John A. Comings, Samuel Ayres, E. P. Miller, Henry S. Plympton, Wm. O. Meagher, T. H. Stillwell, George R. Wells, J. W. Robie, B. J. Dewey, A. D. Smith, C. R. Chase, B. O. Reynolds, C. H. Baker, Calhoun Hill, and Robert McKun. Dr. J. P. Garrish, one of the Professors of the Hospital, delivered an address to the students, and the Valedictory was spoken by Dr. James F. Kiernan of the graduating class.

Obituary.

DR. FRANCIS.

John Wakefield Francis was born in the city of New York, on the 17th of November, 1789. His paternal ancestry was German, his father having emigrated to this country soon after the Revolution. His mother was of Swiss parentage, being at the time of her marriage a resident of Philadelphia. We first hear of the subject of our biography in active life as an apprentice to a printer, Mr. George Long; and though he pursued the business but for a limited period, he was ever after popular with the typographical profession, and took a conspicuous part at their festivals. The thirst for knowledge which characterized his subsequent life, now awakened in him, and he sought greater advantages for learning. We soon after find him pursuing the preliminary studies of an academical course, his preceptors being the Rev. George Strebeck and the Rev. John Conroy, of Trinity College, Dublin. He entered an advanced class of Columbia College in 1807, and was graduated A.B. in 1809, at the age of twenty. He had already selected the profession of medicine, and commenced his studies under Dr. Hosack. He was graduated M.D. in 1811 by the College of Physicians and Surgeons; this was the first class of graduates from that school, eight in number, one of whom was the late Dr. T. Romeyn Beck. Soon after his graduation, Dr. Francis formed a partnership with his preceptor, which continued until 1820. In 1813, at the age of twenty-four, he was appointed lecturer on the Institutes of Medicine and Materia Medica in the College of Physicians and Surgeons. It was about this period that he visited Europe for the purpose of self-improvement, where he formed the acquaintance of many of the prominent persons of that period, viz. Cuvier, Gall, Dupuytren, Playfair, Bell, Abernethy, and Sir Walter Scott. He also became acquainted with Dr. Rees, the author of the *Encyclopædia*. To this he contributed several articles.

Columbia College and the College of Physicians and Surgeons were soon after united, and in the new faculty we find the name of Dr. Francis associated with the Chair of Materia Medica. This position he held until 1816, when the Chair of Materia Medica was united to that of Chemistry, and he was transferred to that of the Institutes of Medicine. In 1817, the Chair of Medical Jurisprudence, previously filled by Dr. James S. Stringham, was united to that of the Institutes, and its duties discharged by Dr. Francis, until 1820, when he succeeded to the Chair of Obstetrics and Diseases of Women and Children, which he filled until 1826, when the entire faculty resigned. A new organization was immediately effected, called the Rutgers Medical College, which was continued four years, and in which Dr. Francis held the Chair of Obstetrics and Forensic Medicine. With the discontinuance of this school, his career as a public teacher was brought to a close.

It will be seen that for eighteen years of the most active period of his life, Dr. Francis was engaged in the praiseworthy effort of laying the foundations of our metropolitan schools. Of his success as a medical teacher, we have the most ample assurance in the rapid growth of the schools with which he was connected, and the important chairs which were successively committed to his charge. That he brought to the elucidation of his subject a mind well stored with facts, gathered by patient research, and close

analytical investigation, an apt faculty for illustration, and a concise and elegant expression, no one familiar with him in after life can doubt. Among his colleagues we notice the honored and historic names of HOSACK, MITCHELL, OSBORN, POST, HAMERSLY, STRINGHAM, MOTT, GODMAN, and BUSHE. All have passed away except MOTT, who, though four years the senior of Dr. Francis, still lives to enjoy a world-wide reputation, and to witness the ever-widening influence of those institutions whose broad foundations he with Dr. Francis assisted to establish.

As an author Dr. Francis has always ranked deservedly high. As early as 1810, while yet a student, he issued the prospectus of the *American Medical and Philosophical Register*, in connexion with Dr. Hosack, his preceptor. This was published quarterly, and continued four years. In 1822, he established, in connexion with Drs. Beck and Dyckman, the *New York Medical and Physical Journal*, with which he remained connected three years. These publications contain many valuable papers from his pen. Of his professional papers those which have attracted most attention are, "Use of Mercury" (an inaugural thesis, 8vo. 1811); "Cases of Morbid Anatomy" (4to. 1814); "Febrile Contagion" (8vo. 1816); "Letter on Cholera Asphyxia" (8vo. 1832); "Observations on the Mineral Waters of Avon" (1834). Most of his later writings were limited to biography and early local history. Among his very latest productions we may notice two biograph cal sketches, contribut ed tothe recent work on Medical Biography by Prof. Gross.

In reviewing the career of Dr. Francis as a medical man, we can but pronounce his life one of eminent usefulness in his profession. We have already alluded to the fact that as a teacher and writer he has done much to establish our medical schools. But various are the methods by which his influence was brought to bear upon the growth and development of the medical institutions of our city during the last half century. There were few that he was not at some period associated with, and he always brought to the discharge of his duties great zeal and practical knowledge. He was one of the original founders of the Academy of Medicine, and was its first President. His addresses before this body are among its best productions. He was early identified with Bellevue Hospital, and as the President of its Medical Board, has done much to place that institution in its present position. As a practical teacher he early recognised the importance of clinical instruction as an essential part of a complete course of education; and, in his annual addresses to the students, he forcibly and eloquently set forth the necessity of careful bedside study, and pointed out the advantages which were there afforded to the clinical student. He was an early and devoted friend of the Woman's Hospital, and but a few days before his death was elected President of the Board of Officers of the State Inebriate Asylum. Thus in every work of charity and usefulness where his services were needed, we find Dr. Francis an earnest and zealous laborer, and often fulfilling engagements at a great sacrifice of personal comfort and even health.

In literature Dr. Francis has long been known as a genial writer of biography, and an accurate delineator of the early historical characters of New York. This department of literature, always very attractive to him, in the latter part of his life engaged much of his attention. The result is seen in his "Old New York," first presented to the public as an address before the Historical Society, but subsequently enlarged to a volume of nearly four hundred pages. In this work the author exhibits to great advantage his peculiar traits, viz. an accurate memory, a nice perception of character, a genuine appreciation of goodness in individuals, and a generous charitableness towards faults. In literary circles Dr. Francis has long enjoyed an unbounded popularity. This was due not so much to his writings as his familiarity with the personal history of the principal characters in every department of literature, his thorough appreciation of their individual peculiarities, and the exhaustless fund of anecdote which was thus at his command, and which, with racy wit and humor, never failed to entertain. At public literary or professional festivals he was a necessary guest, and was always exceedingly happy in his addresses.

As a citizen Dr. Francis occupied an honorable position. Though his labors have been much connected with institutions of charity, and hence are not of a kind to attract public attention, yet he was familiar with our civic history, and was intimately acquainted with the most eminent citizens. Among his friends he could mention Clinton, John Pintard, Egbert Benson, Robert Fulton, Cadwalader Colden, and many others not less distinguished among the leading citizens half a century since; and in later times he was on terms of familiarity with many of the more prominent statesmen of the country.

Dr. Francis represented an era in our professional and social history long past. No scholar studied more assiduously, and was more familiar with the progress of the medical sciences, and the sciences in general, art, literature, and all that pertains to the development of man's social and intellectual nature. Still his early teachings and associations had produced convictions which he was slow to yield, and to which he recurred with gradually increasing interest; though perfectly familiar with the current medical theories he never allowed them to control, and seldom to influence his previously settled opinions. The modern expectant and stimulating plan of treatment found little favor with him. In his social habits, his dress, and his manners, he assimilated the past rather than the present. His physique was an admirable type of the old Knickerbocker, which was improved to the best advantage by his low-crowned and broad-rimmed hat, flowing white hair, gold spectacles, white cravat, and gold-headed cane.

Dr. Francis lived to a ripe age. Honors clustered thickly around him, sufficient to gratify the highest ambition. He received the degree of LL.D. from Columbia College, and was an honorary member of many foreign Societies. Most of our local Societies numbered him as a member, and over many he was at some period the presiding officer. His latter years, we regret to add, were clouded by severe domestic affliction, in the loss of a son to whom he was tenderly attached, and upon whom he leaned for support in his advancing years.

In the death of Dr. Francis the medical profession has lost an earnest and long-tried friend, and a noble example of the humane and liberalizing spirit of the medical sciences; literature one of its most genial devotees; and society a large-hearted philanthropist.

Reviews.

TRANSACTIONS OF THE AMERICAN MEDICAL ASSOCIATION. Vol. XIII. Philadelphia. 1860.

(*Continued from page* 134.)

THE Section on Practical Medicine and Obstetrics furnishes three papers. The first is *On the Influence of Alcoholic Drinks on the Development and Progress of Pulmonary Tuberculosis*, by N. S. DAVIS, M.D., of Illinois. Prof. Davis seems to have given considerable attention to this question, which has now been before the medical world for several years. He has recorded 210 cases, which he divides into three classes: 1. The habitual drinker; 2. The occasional drinker; 3. The temperate. There were 68 of the first class, 91 of the second, and 51 of the third. Their nativity was as follows: Ireland, 85; United States, 60; Norway and Sweden, 25; Germany, 20; England, Scotland, and Wales, 15. The histories of ten cases are given, as examples of the entire collection. The conclusion of the author is, "That neither the action of alcoholic stimulants on the functions of the human body, nor the actual results of ex-

perience, furnish any evidence that these stimulants are capable of either preventing or retarding the development of tubercular phthisis."

The second report is *On the Education of Imbecile and Idiotic Children*, by H. P. AYRES, M.D., Fort Wayne, Indiana. This is an elaborately written paper, being for the most part a compilation from the writings of those devoted to the study of idiocy and its relief. It embraces interesting statistics of this class of persons, and the theories and discussions of authors. Although it is far too extended, and the material is not arranged with much skill, yet if it attract the attention of a single physician so as to lead him to the resolution to use his efforts for the improvement of this unfortunate class, we shall not regret the space it occupies in the Transactions.

The third and last report is *On Inebriate Asylums*, by C. MCDERMONT, M.D., of Dayton, Ohio. This short paper is an earnest appeal in behalf of the Inebriate Asylum, as an essential means in the cure of the drunkard. The true remedy for this evil, he contends, "consists in separating the drunkard from his intoxicating draught." This may be done by, 1, prohibiting the manufacture of ardent spirits; 2, by placing the inebriate in an asylum where he shall be delivered from the temptation to drink. The first method he considers impracticable in the present state of society; the latter is, therefore, to be regarded as the measure to be advocated and adopted. We agree with the author in his advocacy of the Inebriate Asylum as the last hope of the drunkard. The report refers in terms of proper commendation to the enterprise of Dr. Turner, at Binghampton, New York, and looks hopefully forward to the period when Ohio shall follow the suggestion of its governor, and establish a similar institution.

The reports by standing committees, viz. *On Medical Education*, by D. MEREDITH REESE, M.D., LL.D., *On Medical Literature*, by D. F. WRIGHT, M.D., of Nashville, we shall pass without further notice.

The concluding report is *On American Medical Necrology*, by CHRISTOPHER C. COX, A.M., M.D., of Maryland. This report is a new but most interesting feature in the Transactions. The author has shown great assiduity in the collection of the materials for his report, and is entitled to great credit. He complains, and justly too, that his circulars have not been responded to promptly, and concludes by advising the continuance of these necrological records. We heartily second this suggestion.

Progress of Medical Science.

PHYSIOLOGY AND PATHOLOGY.

By W. H. THOMSON, M.D.

1. *Production of Sugar with relation to the Resorption of Fat and to Animal Heat.*—At the meeting of the French Academy, Nov. 9th, 1860, a paper on this subject was read by M. Colin, in which he maintains, 1st. That the resorption or combustion of fat, the production of sugar, and the maintenance of animal heat, at its normal standard, are processes intimately connected with each other, and mutually interdependent. 2d. That abstinence cannot be borne long by lean animals, for a very rapid lowering of temperature takes place in them, coincident with an almost complete disappearance of sugar in the liver, the blood, the lymph, and other fluids, which normally contain it. 3d. That in fat, or moderately fat, individuals, the tolerance of abstinence, other things being equal, is exactly proportioned to the quantity of fatty material stored in the tissues; so long as the animal has fat, life is maintained, the sugar is renewed in the liver and the nutritive fluids, and the system's temperature is not notably lowered. 4th. During hybernation the production of sugar preserves an activity parallel with the resorption of fat. 5th. In animals deprived of nourishment, the liver experiences the most notable changes, extending towards complete atrophy, the cells losing their fat, which is replaced by sugar.—(*Gaz. des Hôpitaux*, Nov. 13th, 1860.)

We do not think that fat is only fuel, but, on the contrary, that it is as necessary and as much a primary element in nutrition as albumen itself; for it is to be found in all growing cells, or parts, as in the embryo, which are undergoing rapid development. The results from experiments of depriving animals of the oleaginous elements of food are evidence of this, while the beneficial effects of oils in the chief diseases of nutrition seem to be owing to their acting as restoratives by supplying an element lacking in the process of tissue-making. Lewes goes so far as to suggest that the main office of the spermatozoa is the requisite supply they afford to the ova of fat to start them in their course of evolutions! These diverse facts seem to indicate that fat exists in the economy under two widely different conditions, with very important distinctions between them in properties, uses, and destiny, the first belonging to the ascending scale of elements, as it enters largely into the composition of the most elaborate and highest products—*e. g.* nerve vesicle or spermatozoon; while the second is a retrograde body, or even a degeneration from albumen (Addison), and capable of nothing better than combustion. One of the conclusions from this view would be, that according as an artificial oil approaches in its characters the one or the other fat in the system, will it be of use in the treatment of the diseases of nutrition.

2. *Secretion of Milk from the Axilla.*—Instances of the secretion of milk by various surfaces of the body, such as from the umbilicus, etc., have been made a good deal of by some physiologists fond of generalizations, as evidence of original identity in type of all secreting organs. We cannot but entertain some question, however, as to the real nature of the supposed milk in the out-of-the-way localities named, except in those cases where the lacteal fluid has made its inconvenient appearance in the armpit; for the true connexion here is conceivable, and made out, we think, in the facts of the following case from the *Dub. Med. Press*, Nov. 7, 1860, related by Dr. C. J. Hare. Mrs. M. S——, æt. 37, presented herself with a small swelling under the right arm, which for some time past had given out a white, milky-looking discharge, presenting exactly the same appearance as the milk from the breasts. She had been confined of her seventh child, had suckled all her children, and at no period of her former lactations, or at any other time, had she observed a swelling in the axilla. It was on the night of her confinement that she first observed it, and, when first noticed, she described it as being of the size of half a walnut. It did not increase much in bulk, but became harder, and caused some pain as low down as the elbow. It was not until the end of a month that it discharged a little fluid, which was then of a decidedly milky appearance; and as she was engaged in her domestic avocations, enough generally escaped to moisten the linen every day since that, and sometimes even more. On examining the axilla, I found an irregularly ovoid prominence about as large as a filbert, with a moderately defined outline, somewhat blended with the loose cellular tissue of the axilla. Its substance was firm, but not hard or resisting, as an enlarged gland in that situation usually is; for by moderate pressure its shape could be readily altered, though it instantly resumed its original form on the pressure being removed. The skin over the swelling presented no redness or any difference from the rest of the axilla; there was no trace of a nipple; and so exceedingly minute was the aperture through which the fluid escaped, that it was impossible to say at what point it made its appearance, until the surface had been wiped quite dry, and a fresh portion had been forced out by pressure. The fluid had all the usual appearance of normal human breast-milk, being a thin, bluish-white liquid, rather sticky when rubbed between the fingers. A small quantity collected in a test tube was

found, after a few hours, to form on its surface a layer of cream. A drop of the fluid being, as soon as collected, placed under the microscope, it was found to be rich in the variously-sized oil globules of milk: nothing resembling a pus globule was detected. I exhibited a specimen of the milk to the Pathological Society, so late as Sept. 14th, when the condition of affairs was apparently exactly the same as in May, and microscopical examination gave exactly the same results as before. The only question which presents itself is as to the source of the secretion—whether the milk was secreted by a portion of mammary gland situated in the axilla, or was conveyed to that part in some unusual manner from the breast. It is possible to conceive that a communication might have become established between a portion of the breast and some of the lymphatics, and thus a little milk might be conveyed to a lymphatic gland in the axilla; that the gland enlarging had given rise to the swelling felt, and ultimately allowed the milk to escape as described. But all the evidence is in favor of the small mass in the axilla being really a portion of true mammary substance situated there. The physical characters presented by the swelling, the absence of hardness, the elasticity, etc., were not those of an enlarged lymphatic gland; nor is it probable that such a gland would have continued so absolutely stationary for so many months, or the skin above it so free from redness, so mobile, and in such a healthy condition; and it is to be remarked that the increased flow from the axilla took place at the same time that milk was being *drawn* from the breasts."

A case is also recorded by Dr. J. Harris, in the *Savannah Jour. of Med.*, Oct., 1860, of a negro woman, who, after the birth of her third and fourth children, experienced large swellings in the axilla, which continued without interference during lactation. The same swellings occurred after the birth of her sixth child, when they were tapped, and a pint of fluid evacuated, which, under the microscope, showed milk globules, very characteristic colostrum corpuscles, and no pus globules; and chemical examination proved the existence of all the constituents of colostrum and milk. As the mammary gland is conglomerate, with its parts united by cellular tissue, it is readily conceivable that one of the divisions, through some original defect in the "constitution," has seceded into the axilla, and set up separate sovereignty, rather than that such cases are proofs of secretion being essentially the same process wherever it occurs, so that the stomach can easily become a urinary bladder, and the umbilicus flow with milk and butter.

Correspondence.

NEW YORK INFIRMARY FOR WOMEN AND CHILDREN.

[To the Editor of the American Medical Times.]

Sir:—Having read with some surprise the leader entitled "A New Question in Ethics," in your last week's issue, we should be much obliged if you would publish the following statement of the history and object of the institution referred to, as we desire that they should be fully understood by the Profession.

The New York Infirmary for Women and Children was commenced in 1853 as a dispensary, near Tompkins Square, with a regular charter and organization. In 1857 it grew into a small hospital, and was placed in the hands of suitable persons, we retaining such medical oversight as a daily visit would allow. Finding, however, that this arrangement was unsatisfactory, that the institution required more of our influence than the cares of a large and increasing private practice would allow us to give while residing at a distance, it was removed in 1860 to its present location, and in accordance with the wish of the Trustees we assumed the personal superintendence of it. The main object of the Infirmary is to provide for ladies, who are engaged in the study of medicine, opportunities for seeing and assisting in practice. It proposes to accomplish this in a twofold way: 1st, By furnishing a large amount of poor practice, both outdoor and indoor, in which its students take part; 2d, By presenting such guarantees to the Profession of intelligence and earnestness on the part of its students, that they may in time gain admittance to other public medical charities of our city. The Infirmary is, therefore, designed as a medical centre for women; its patients come entirely from the poor; it receives medical students; is under the direction of well known citizens. It has a board of eminent consulting physicians, and will in time, as it grows in wealth and gains the confidence of the profession, obtain for women what they do not at present enjoy—the opportunity of acquiring a good medical education.

It has necessarily been of slow growth; for, as we commenced practice in New York nine years ago, not only without a friend, but without a single acquaintance, in the whole city, the formation of even a small institution has been a very heavy burden to us. It is, however, fast gaining friends, as will be seen from the Report, and we hope in time to be relieved from the great responsibility which has hitherto rested upon us.

Should any members of the Profession feel any interest in this institution, they are cordially invited to visit it, and obtain its published reports, or any information they may desire.

In relation to the "New Question in Medical Ethics," it may be interesting to the Profession here to know that the question was settled in England two years ago, when the "General Council of Medical Education and Registration of the United Kingdom" received the testimonials of a lady physician, and enrolled her name in the Medical Register for 1859.

E. & E. Blackwell.

126 Second Avenue, *Feb. 25th*, 1861.

THE CONICAL TREPHINE.

[To the Editor of the American Medical Times.]

Sir:—In the number of the Medical Times of February 5, to which I desire briefly to allude, I notice an article in reference to the Trephine which I originated, and introduced to the consideration of the profession. In presenting this instrument, in April last, to the surgical section of the Academy of Medicine of this city, I distinctly stated, that when I devised it, my impressions were that the cone was an original idea of my own, but on examination of the Atlas of Blasius I learned that a trephine had been in use, of a conical shape, with longitudinal peripheral teeth. I found after testing it, that that instrument possessed very little advantage over the old one now in use, inasmuch as it continues to cut after dividing the cranial walls, and consequently must wound the membranes and brain substance. After satisfying myself of the pre-existence of the instrument described by Blasius, I of course abandoned all intention of claiming any originality in the conical form of my trephine; and only maintained its superiority in the spiral arrangement of its peripheral teeth. In doing this I did not desire to detract from any antecedent claims to originality in the invention of a similar instrument. I thought, from my limited observation, that I had discovered a new principle of mechanics, which being brought to bear upon the trephine would give it superior advantages to any I had seen. Acting upon this principle, I completed the one in question. Not satisfied with my own preconceived partiality, but desiring the opinions of those in whom I had confidence in reference to its merits, I not only consulted various intelligent surgical gentlemen, but personally introduced it to the surgical section of the Academy of Medi-

cine. The members were competent to judge of its efficiency, and whether it had any claims to originality in its design. They were familiar with surgery and surgical instruments of this country and Europe; many of them had studied in the schools of France and Germany, yet no mention is made by any of them in reference to a trephine, which I am informed by your correspondents is "generally used there." Strange that none of these intelligent medical gentlemen should have met with it, and still more strange that in all their researches in the history of the profession they should have overlooked an instrument which we might infer was well known to surgery.

Not alone to the profession in this city has this trephine been presented; but through the various medical and surgical journals it has been brought to the consideration of thousands of the profession in Europe and this country, yet among those who are presumed to be well versed in medical history, no one has as yet suggested any satisfactory disproval of my claims to originality. The *New York Journal of Medicine*, May, 1860, contains an article in reference to the various tests to which my trephine had been submitted, and the very satisfactory results therefrom as to its efficiency. The editor accompanies the article with a diagram of the trephine, and remarks, "that it was highly commended by the surgeons present, and will, we believe, prove a valuable and most important invention." The *Nashville Journal of Medicine and Surgery*, Oct. 1860, contains a similar article, and endorsing the views of the *New York Journal*. *Braithwaite's Retrospect of Practical Medicine and Surgery*, uniform American edition, Jan. 1861, contains a similar notice of the instrument in question, which is copied from the *British Medical Journal* of June 16, 1860. In addition to the above, we have a similar article which appeared in your Journal of January 5, 1861, in connexion with a successful operation performed at Bellevue Hospital by Dr. Sayre, and the courteous endorsement by him of the merits of this trephine. I can therefore logically conclude that the surgical profession have not been ignorant of my claims to this invention, as the evidences I have cited are ample as to publicity being given to it. What are the evidences upon which we are to rely as to the previous introduction and use by surgeons of any instrument professing to be novel in its design? It is not the verbal assertion of any one, unsustained by concurrent written testimony; but the surgical plates of those instruments corresponding with the surgical description accompanying them. This coincidence is indispensable to demonstrate the accuracy of the diagram, otherwise there is no determining as to whether it might not be an artistic error. I have consulted all the medical authorities to which I have had access, and have found none to impair the validity of my claims to this invention. I have examined the *Synopsis Medicinæ*, by Salmon, London ed. 1860, in which a very large number of surgical instruments are delineated, among them the conical trephine to which I alluded, but it has the longitudinal, and not the spiral arrangement of its peripheral teeth. I find the same principle obtains in the publications by Blasius, Heister, and in the treatise of Ambrose Paré, so early as 1579. These are all recognised authorities of high character; they all coincide in their description of a conical trephine, but it is the same as the one in the *Synopsis Medicinæ*, and does not meet the principle involved in that designed by me.

Your correspondents refer us to an "antique case of instruments in their possession, which contain trephines similar to ours, and of which they apprise the profession they expect to keep a supply." I am far from reflecting any imputations upon these gentlemen, or misinterpreting the disinterestedness of their intentions, but to the prejudiced their concluding paragraph might admit of unfavorable construction.

I, however, do not desire to render myself annoying to an indulgent profession in reference to this matter. I have expended much thought and labor upon my instrument, and repeatedly failed before I accomplished my purpose. The idea, at least, was an original one with me—having never seen any instrument similar in character to it, or which would combine its advantages, though such a one may have existed among the "antiquities" of the profession. I only desire to maintain the position awarded me by our confrères, of having made some humble contribution to surgical science.

G. A. D. Galt, M.D.

New York, *Feb.* 25, 1861.

INHALATION OF NITRATE OF SILVER.

[To the Editor of the American Medical Times.]

Sir—I notice in your number of February 2, an article upon the *Inhalation of Nitrate of Silver*, by Dr. Fetter. I fully agree with the Doctor that if nitrate of silver must pass below the epiglottis, that his method, or something similar, is far preferable to the use of the probang. But what particular advantage, other than that of economy, his method can have over the caustic pulverizer, as previously used, I am at a loss to see. Both, in my estimation, have their disadvantages, and perhaps dangers. I must confess that I would not be willing to make a "strong inhalation or inspiration" upon a heap of powdered nitrate of silver, placed in a "small glass tube," for a reason which is by no means fancied. Having been a sufferer, I have tried to do it. I found that unless I was extremely cautious and gentle in my inspiration, the mass was pretty sure to go in a body, and either lodge somewhere on the back of the pharynx, about the glottis, or along the larynx, and give rise to very unpleasant sensations. I therefore abandoned this process, as I had previously done the probang, and after a number of subsequent plans, finally hit upon the following, which I found in all respects safe and most efficient, and which I sent to the *Chicago Medical Journal*, July 1858, from which I quote.

"I pulverize the nitrate of silver in a moderately heated wedgewood mortar, to an impalpable powder; I then triturate it with sugar of milk, according to the strength which I desire—generally mixing them in the proportion of one part of the caustic to two of sugar of milk. This powder I put into a glass-stoppered jar of the pint or quart size, being careful to have the jar thoroughly dry by heating it. I place in the patient's mouth a glass or tin tube, one inch in diameter, and some eight or ten inches in length. Giving the jar a good shake and pulling out the stopper, I tell the patient to plunge the tube into the mouth of the jar and inhale. The cloud of powder which was seen floating in the jar, passes into and sprinkles the air-passages thoroughly. From one to three inhalations at a time is sufficient, and about twice or thrice a week. The powder can be kept in good condition for about a month, the main trouble being the heating the jar every time you wish to use it, in order to drive off whatever atmospheric moisture may have collected. In all instances where it is desirable to go below the epiglottis with this remedy, I know of no way more efficacious than this, and being simple it is within the reach of all."

W. H. Studly, M.D.

Yorkville, Feb., 1861.

ATTEMPT AT SUICIDE, BY SWALLOWING CHLOROFORM.

[To the Editor of the American Medical Times.]

Sir—Julia Wilson, aged eighteen, attempted suicide on Tuesday evening, December 4, 1860, by swallowing one ounce of chloroform. She sent the servant girl to the nearest apothecary, with directions to procure one ounce of the material. No questions were asked by the dispenser, and a vial marked "chloroform," was handed by him to the purchaser. On returning home, the girl gave the vial to Miss W., who closed the parlor door, and then swallowed the contents of the bottle. She walked the length of the parlor twice, placed the empty phial on the mantel-piece, and then fell

heavily on the floor. The noise occasioned by the fall soon brought several members of the family to her assistance. I was sent for immediately, and arrived at the house about twenty minutes after the drug had been taken. She was at this time lying on the sofa, complaining of a burning sensation at the stomach. The pulse was feeble and quick, the countenance pallid, and the extremities cold. She refused to take any medicine, but, with the assistance of those around her, I succeeded in forcing down the throat one ounce of powdered ipecac, mixed with a little warm water. In a few minutes she commenced vomiting, the odor of chloroform being distinctly detected in the materials ejected from the stomach. She, however, became gradually comatose, with stertorous breathing, pulse feeble and rapid, pupils contracted and insensible to light. The finger rubbed over the conjunctiva gave no evidence of sensibility. It was now forty minutes from the time that the poison had been taken. Mustard applications were freely applied to the extremities, cold water dashed on the face, and flagellation kept up at short intervals. She remained in this condition about half an hour, when consciousness became gradually restored. As this took place, she passed through the different stages usually observed in persons who take chloroform by inhalation. At 11 o'clock P.M., just three hours from the time the anæsthetic was taken, she was in her usual health, having entirely recovered from its effects. Taylor, in his Medical Jurisprudence, relates a case where one drachm taken into the stomach caused death. Another, where four ounces were taken, and the man recovered in five days. In the case of Miss W., the quantity taken, it will be recollected, was one ounce. She supposed that in order to cause death, the chloroform must be taken into the stomach, like laudanum.

T. C. Finnell, M.D.

132 W. Houston Street.

A CASE OF MONSTROSITY.

[To the Editor of the American Medical Times.]

Sir:—On the 25th of December last I attended a lady near this place in her second confinement, who gave birth to an acephalous fœtus. There was also a bifid spine; and nearly the whole extent of the back was denuded of integument. The lower limbs were perfectly formed. The fingers were of unusual length, and were clenched so firmly that they could not be opened without breaking them. There was a sac, the size of a hen's egg, lying externally between the shoulders, which, upon opening, I found contained a substance resembling brain matter. The woman was at about the eighth month of her pregnancy. The monster showed no symptoms of life after birth. There was nothing remarkable in the history of the gestation, so fas as I could learn, unless we might mention slight flooding at the third month.

F. N. Smith, M.D.

La Harpe Ill., Jan. 30, 1861.

Medical News.

DEATHS.

Jones—In New York city, February 12, Julia C. Stuart, wife of E. Lee Jones, M.D., in the 22d year of her age.

Griswold—In New York city, February 26, Stephen, only son of Dr. Stephen and Cornelia R. Griswold, in the 4th year of his age.

APPOINTMENT.

New York Hospital.—Dr. C. E. Hackley has been appointed Resident Physician in place of Dr. R. F. Weir, resigned.

The Parisian journals announce the recent deaths of the following physicians, viz. Dr. Tiedmann, aged 87, at Munich; Dr. Germa, aged 86, at Paris; and Dr. Van Vaerenbergh, aged 84, at Antwerp.

A London physician recently received a fee of £5,000.

Army and Naval Intelligence.—Assistant Surgeon C. G. Hollenbush has been assigned to duty at Fort Pickens, Fla. Surgeon D. C. De Leon has resigned; resignation to take effect Feb. 19, 1861. Dr. Woodworth, surgeon to the Niagara, being invalided, returns to the United States by the way of Egypt.

Board of Naval Surgeons.—Official.—A Board of Surgeons will convene at the Naval Asylum, Philadelphia, on Friday, March 1st, 1861, for the examination of Assistant Surgeons for promotion, and candidates for admission into the Medical Corps of the Navy. The following Surgeons compose the Board:—James M. Greene, M.D., President; J. M. Foltz, M.D., and C. H. Wheelwright, M.D., members; Passed Assistant-Surgeon Jno. F. Taylor, M.D., Recorder. Assistant-Surgeon Stewart Kennedy, and William Johnson, Jr., have been ordered, and Assistant-Surgeons A. M. Vedder, P. S. Wales, and A. C. Gorgas have received permission to appear for examination for promotion. The three last named have not been in the Navy the required time to entitle them to an examination, but as the exigencies of the service may require them at sea, when the next Board meets, they have been permitted to appear before this Board. Should they pass, they will not receive their rank as Passed Assistant-Surgeons, or additional pay, until the expiration of five years from the date of their entry into the service. Candidates for admission into the Corps must not be under twenty-one or over twenty-five years of age, and cannot appear before the Board without permission of the Secretary of the Navy, which can be obtained by furnishing the Department with respectable testimonials as to the moral and physical qualifications of the applicant.

The Surgeon-General's Department.—We understand that numerous tenders of service in the surgical staff of the State have been received from New York, Rhode Island, Pennsylvania, Indiana, Arkansas, Maryland, Virginia, Alabama, Georgia, Florida, and North Carolina. Some of the medical gentlemen have volunteered for the position of Hospital Stewards, rather than not serve South Carolina.—*Columbia (S.C.) Banner.*

Gas and Oil.—The cheapness of gas, as compared with other modes of procuring artificial light, may be seen from the following table:—It must be borne in mind that this table is made for the English market, showing, as it does, at what a low rate gas can be manufactured, and still pay fair dividends. According to this table, gas is afforded at the low sum of one dollar per thousand cubic feet in this city, and one dollar and twenty-five cents in the suburbs. Gas from cannel coal being much better than that made from ordinary coal, containing, as it does, more body, a higher rate is charged for the gas. The price received for this quality of gas is one dollar and fifty cents, or six English shillings. The machinery for the manufacturing gas in England is far superior to any in this country, and they also make a saving of nearly twenty per cent. on their method of washing or purifying the gas. This table has been computed with great care, merely altering the prices of gas to the rate as afforded at the present time:—

COMPARATIVE COST OF LIGHT, FROM CANDLES, LAMPS, AND GAS.

		Quantity and price of candles and oil.			Quantities and prices of gas for an equal light.				
						At 5s. per 1,000		At 4s. per 1,000	
		s.	d	C. ft				
Tallow candles, (dip.)	lb.	1	0	6	21	0	1½	0	1
" " (moulds)	"	1	0	8	21	0	1½	0	1
Composition, "	"	1	1	0	25	0	1½	0	1¼
Wax candles, "	"	1	2	4	25	0	1½	0	1¼
Solar and pale seal oil,	gall.	1	4	0	175	0.	10½	0	8½
Sperm oil, . .	"	1	8	0	217	1	1	0	10½

This table shows that gas is only about one-sixth the price of tallow, or one-twentieth that of wax candles, and one-eighth that of sperm oil.—*Merchants' Magazine.*

COMMUNICATIONS have been received from:—

Connecticut—Drs. A. C. Woodward, A. Woodward. *Florida*—Dr. J. Irons. *Illinois*—Dr. A. B. McChesney. *Indiana*—Dr. H. Duncan. *Iowa*—Drs. L. H. Carey, A. T. Hudson, J. Langer. *Maine*—Drs. B. F. Peirce, W. H. Stevens. *Massachusetts*—Drs. E. Cutter, A. W. Thompson. *New Hampshire*—Dr. J. A. Wheeler. *New York*—Drs. H. W. Carpenter, C. C. F. Gay, W. P. Bell, H. B. Wilbur, C. H. Shears, C. J. Robinson, L. G. Sherman, L. M. Wheeler, M. C. Northrup, J. R. Bird, J. H. Jerome, J. H. Tanner. *Ohio*—Drs. G. W. Baeksdale, C. H. Price, J. T. Read, C. O'Leary, C. E. Withaus, W. Clendenin, J. C. Reeve. *Pennsylvania*—Drs. J. W. Keer, W. Anthony. *Tennessee*—Dr. J. B. Smith. *Vermont*—Drs. L. Chase, E. A. Knight.

METEOROLOGY AND NECROLOGY OF THE WEEK IN THE CITY AND COUNTY OF NEW YORK,

From the 18th day of February, 1861, to the 25th day of February, 1861.

Abstract of the Official Report.

Deaths.—Men, 76; women, 81; boys, 119; girls, 114—total, 390. Adults, 157; children, 233; males, 195; females, 195; colored, 4. Infants under two years of age, 144. Among the causes of death we notice:—Infantile convulsions, 29; croup, 13; diphtheria, 11; scarlet fever, 31; typhus and typhoid fevers, 13; consumption, 51; small-pox, 6; dropsy of head, 13; infantile-marasmus, 17; puerperal fever, 6; inflammation of brain, 12; of lungs, 34; bronchitis, 8; congestion of brain, 10; of lungs, 6; erysipelas, 7; whooping cough, 3; measles, 8. 274 were native, and 116 foreign; of whom 78 came from Ireland; 7 died in the Immigrant Institution, and 40 in the City Charities; of whom 16 were in the Bellevue Hospital.

Abstract of the Atmospherical Record of the Eastern Dispensary, kept in the Market building, No. 57 Essex street, New York.

Feb'y. 1861.	Barometer.		Temperature.			Difference of dry and wet bulb. Thrm.		Wind.	Mean amount of cloud.	Rain.
	Mean height.	Daily range.	Mean	Min.	Max.	Mean	Max.			
	In.	In	°	°	°	°	°		0 to 10	In.
17th	29.45	.25	40	36	46	6	11	S.W.	2	.3
18th	29.67	.15	36	28	46	5	8	"	4	
19th	29.90	.30	36	30	44	5	9	"	5	
20th	29.75	.50	40	31	52	5	9	"	5	
21st	29.70	.40	36	30	43	5	8	W.	4	
22d	29.99	.30	35	27	44	5	9	"	1	
23d	29.70	.40	40	36	45	5	8	N.E.	6	.05

Remarks.—17th, rain early A.M., fresh wind A.M., variable skies P.M. The weather for the first five days of the week was variable, like that of March, with very light showers and snows. 22d, wind fresh A.M. 23d, sleet A.M., rain, P.M.

Error in rain column, of last week 1.99, 1.99, 1.99 } should be { 1.97.

MEDICAL DIARY OF THE WEEK.

Monday, Mar. 4.
- New York Hospital, Dr. Halsted, half-past 1 P.M.
- Eye Infirmary, Diseases of Eye, 12 M.

Tuesday, Mar. 5.
- New York Hospital, Dr. Buck, half-past 1 P.M.
- Eye Infirmary, Diseases of Ear, 12 M.
- Ophthalmic Hospital, Drs. Stephenson & Garrish, 1 P.M.

Wednesday, Mar. 6.
- Eye Infirmary, Operations, 12 M.
- New York Hospital, Dr. Cock, half-past 1 P.M.
- Bellevue Hospital, Dr. Mott, half-past 1 P.M.
- Academy of Medicine, 7½ P.M.

Thursday, Mar. 7.
- Ophthalmic Hospital, Drs. Stephenson & Garrish, 1 P.M.
- New York Hospital, Dr. Halsted, half-past 1 P.M.

Friday, Mar. 8.
- New York Hospital, Dr. Buck, half-past 1 P.M.
- Eye Infirmary, Diseases of Eye, 12 M.

Saturday, Mar. 9.
- Bellevue Hospital, Dr. Wood, half-past 1 P.M.
- Ophthalmic Hospital, Drs. Stephenson & Garrish, 1 P.M.
- New York Hospital, Dr. Cock, half-past 1 P.M.
- Emigrants' Hosp., Ward's Island, Dr. Carnochan, 3 P.M.
- Eye Infirmary, Diseases of Ear, 12 M.

SPECIAL NOTICES.

Academy of Medicine.—*At the next meeting,* Dr. James M. Minor *will read a report from the Section on Surgery* on Artificial Limbs. *This report is the result of the Examination of all the artificial limbs referred to the Section on Surgery during the last two or three years.*

On Myalgia, its Nature, Causes, and Treatment, being a Treatise on Painful and other Affections of the Muscular System, which have been frequently mistaken for hysterical, inflammatory, hepatic, uterine, nervous, spinal, or other diseases, by Thomas Inman, M.D. Second Edition. Illustrated by Bagg. London, 1860. $2.70.

Bailliere Brothers, 440 Broadway, N. Y.

A System of Surgery, Theoretical and Practical, in treatises by various authors, arranged and edited by T. Holmes, M.D. Vol. 1, 8vo. London, 1861. Price, $6.25.

CONTENTS OF THE FIRST VOLUME.

1. Inflammation, by . . . . . J. Simon.
2. Abscess, " . . . . . Holmes Coote.
3. Sinus and Fistula, by . . . . . James Paget.
4. Gangrene, " . . . . . Holmes Coote.
5. Ulceration and Ulcers, by . . . . . James Paget.
6. Erysipelas and the allied Diseases, by . . Campbell de Morgan.
7. Pyœmia, " . . . G. W. Callender.
8. Tetanus, " . . . Alfred Poland.
9. Delirium Tremens, " . . . A. W. Barclay.
10. Scrofula, " . . . W. S. Savory.
11. Hysteria, " . . . W. S. Savory.
12. Syphilis, " . . . Henry Lee.
13. Tumours, " . . . James Paget.
14. Cancer, " . . . C. H. Moore.
15. Contusions and Wounds, " . . . James Paget.
16. Animal Poisons, " . . . A. Poland.
17. Hæmorrhage and Injuries of the Vessels, by . C. H. Moore.
18. Collapse, " . . . W. S. Savory.
19. Burns and Scalds, " . . . T. Holmes.
20. General Pathology of Fractures, " . . T. K. Hornidge.
21. The General Pathology of Dislocations, " . T. Holmes.

The Second Volume is in the Press.

The Third and Fourth Volumes, to complete the Work, will, it is hoped, be published during 1861.

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